RHODE ISLAND

Medical Journal

JULY, 1961

Medical Economics Issue . . .

Volume XLIV, No. 7

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inside as well as outside the hospital... staphylococci usually remain sensitive to

CHLOROMYCETIN

(chloramphenicol, Parke-Davis)

That the sensitivity patterns of "street" staphylococci differ widely from those of "hospital" staphylococci is a well-established clinical fact.[1-5] Although strains of staphylococci encountered in general practice have remained relatively sensitive to a number of antibiotics,[6] the problem of antibiotic-resistant staphylococci appears to be a threat to all patients in hospitals today. It is encouraging to note, however, "...that a relatively small percentage of strains develop resistance to chloramphenicol, despite the consumption of large amounts of this antibiotic."[7]

In one hospital, for example, CHLOROMYCETIN "...was the only widely used antibiotic to which few of the strains were resistant."[8] In another hospital, despite steadily increasing use of CHLOROMYCETIN since 1956, "...the percentage of chloramphenicol-resistant strains has actually been lower in subsequent years."[1] Elsewhere, insofar as hospital staphylococci are concerned, it appears that "...the problem of antibiotic resistance can be regarded as minimal for chloramphenicol."[2]

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Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

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THE WASHINGTON SCENE

A Report Prepared by the Washington Office of the American Medical Association

THE American Medical Association supported the Kennedy Administration's proposal to provide $750 million in matching funds for construction of medical, dental, public health and osteopathic schools.

In a letter to Senator Lister Hill (D., Ala.), chairman of the Senate Labor and Public Welfare Committee, Doctor F. J. L. Blasingame, executive vice president of the A.M.A., said:

"As an Association of 179,000 practicing physicians, we are vitally interested in maintaining the high quality of medical education in the United States because of its direct relationship to medical care. For over a century, the American Medical Association has been actively and effectively engaged in the improvement of medical education in the United States. It can now be said, with assurance, that medical education in this country is superior to that found anywhere else in the world. It is not a coincidence that the improved standards of medical care in the last half century saw the elimination of substandard medical schools and diploma mills which had been turning out graduates in large numbers. This improvement in medical education is the result of the vigorous efforts of this Association and other interested organizations.

"We strongly believe that increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education if high standards of medical education are to be maintained. Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standard of medical education. We are of the firm conviction that increase in the physical facilities available for medical education should be given priority at this time over any other federal legislation in the field of medical education.

"We believe that there is need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools and, therefore, a one-time expenditure of federal funds on a matching basis, where maximum freedom of the school from federal control is assured, is justified."

The A.M.A. opposed a provision that might encourage medical schools to expand too rapidly. Doctor Blasingame said: "It is quite possible that a forced increase in freshman enrollment would be detrimental to the quality of medical education."

The Association didn't take a position on the provision of the administration legislation that would provide federal scholarships to medical students. However, Doctor Blasingame described to the senate committee A.M.A.'s new medical scholarship and student loan programs.

* * *

Medicare Program

The General Accounting Office found the Defense Department's Medicare program being conducted generally "in a satisfactory manner," but recommended some changes designed to correct what it considered "important deficiencies."

The army, which administers the program of medical care for dependents of members of the armed services, took steps to put into effect most of the recommendations of the G.A.O., which audits federal spending for Congress.

However, Medicare officials rejected a G.A.O. proposal for a change in physician fees.

"Our review disclosed that physicians' claims for medical care are, in general, significantly higher in states where maximum fees are made known to physicians than in those states where maximum fees are not made known," the G.A.O. reported. "We estimate that there is an additional cost of as much as $3 million to $4 million annually as a result of maximum fees, rather than normal fees, being charged in the states where fee schedules are distributed to the physicians."

The G.A.O. recommended that lower fixed fee schedules be negotiated for states where a high percentage of physicians' claims are for maximum allowable fees, "subject to being raised only on the basis of clearly supported evidence of higher normal fees."

If lower fees cannot be negotiated, the G.A.O. said, efforts should be made "to have the state medical society or other appropriate parties accept the responsibility for determining that physician claims are generally not in excess of their normal charges."

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in rheumatoid arthritis

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ARISTOCORT Triamcinolone has long since proved its *unsurpassed efficacy and relative safety* in treating rheumatoid arthritis. Mounting clinical evidence has shown that ARISTOCORT is also highly valuable for the "special-problem" arthritic – the patient who, because of certain complications, was hitherto considered a poor candidate for corticosteroids.

for example:

SPECIAL PROBLEM: ANXIETY-TENSION

When triamcinolone was used, euphoria and psychic unrest rarely occurred. (McGavack, T. H.: *Clin. Med.* 6:997 [June] 1959.)

SPECIAL PROBLEM: OVERWEIGHT

No patient developed voracious appetite on triamcinolone. Preferable for the overweight person whose appetite is undesirably stimulated by other steroids. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

Hypertension did not result from triamcinolone therapy. Existing hypertension was reduced sometimes. This may have been due to lack of sodium retention. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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BOOK REVIEWS

PHARMACOLOGY. The Nature, Action, and Use of Drugs by Harry Beckman, M.D. Second Edition. W. B. Saunders Co., Phil. and London, 1961. $15.50

After a brief review of how drugs act in general, an attempt was made to group certain compounds under broad disease headings and others according to their primary action. This fact impressed function upon the reader while introducing currently useful drugs. These were all discussed briefly. A selected bibliography at the end of each chapter was an effort at completeness and adequacy of presentation.

Time-honored compounds were dealt with according to their therapeutic order of importance today, while emphasis was placed upon the more recent contributions to our clinical armamentarium. Countless drugs were thus touched upon within the span of 805 pages. Easy reference to each of these was possible by simply a turn to the complete index of drugs at the end of the book.

I believe that the author has succeeded in organizing data useful to both the busy clinician and medical student. No pretense at completeness was made. More detailed works must be consulted if the comments made fail to answer the individual clinical problem as fully as desired.

ALBERT F. TETREAULT, M.D.

INSTRUCTIONAL COURSE LECTURES, Volume XVII, 1960. Edited by Fred C. Reynolds, M.D. The American Academy of Orthopaedic Surgeons. The C. V. Mosby Co., St. Louis, 1960. $18.50

This is a 421-page book containing most of the instructional course lectures given at the 1960 annual meeting of The American Academy of Orthopaedic Surgeons. The book is exceptionally well written and makes for easy, interesting reading. The contents of the book are divided into five main parts dealing with fractures, bone graft surgery, children's orthopaedics, athletic injuries, and miscellaneous subjects.

The lectures dealing with fractures of the elbow in children together with the diagnosis of arterial injury in the extremities contain a considerable amount of valuable information. It is emphasized that in complicated fractures of the supracondylar section of the elbow in children manipulation and remanipulation should be avoided when the nerve supply and blood supply are jeopardized because of the danger of further damage to the circulation which already has a limited margin of safety. In these cases the authors recommend primary skeletal traction as the initial form of treatment. In addition important suggestions are made in the handling of fractures of the capitellum, medial epicondyle, upper end of the radius, olecranon, Monteggia fractures, and so forth.

The section dealing with the management of fractures of the neck of the femur contains a considerable amount of valuable information. This particular chapter not only describes in detail the management of the various types of fractures of the neck of the femur but it also enumerates the complications which may take place in the handling of these fractures. With reference to the insertion of prostheses, the authors state that replacement prostheses in hip fractures have a definite but limited place. One criticism that might be offered is that some of the authors state that an open reduction is seldom if ever necessary in the treatment of fresh fractures of the neck of the femur and yet one of the authors states that he does an open reduction on 85 per cent of his cases. This wide variance of opinion is apt to confuse the young orthopaedist.

The section dealing with bone graft surgery should prove of extreme interest to the student of the scientific phase of bone grafting. The different methods of operative procedure and indications are enumerated in this section together with well-documented case reports giving the indications for the different types of bone grafts in use.

The section dealing with children's orthopaedics is of particular interest because it gives a very excellent account of bone growth, the factors involved and the various methods used in its control. Doctor Blount's lecture on unequal leg length is of particular interest.

A well-written section is included on the management of the child amputee. This particular section recommends that a child amputee be fitted with a prosthesis early in life in order to avoid functional substitution patterns which the child may be unwilling or unable to abandon later on in life.

Another section which I found quite interesting is the one dealing with the surgical approaches to the cervical spine. Doctors Robinson and Southwick give an excellent dissertation on the indica-

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Made from 100% CORN OIL

BOOK REVIEWS

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tions for operative intervention in various conditions affecting the cervical spine, and they relate the method of approach for such procedures as biopsy of the vertebral bodies, anterior removal of intervertebral discs, interbody fusion, open reduction, stabilization with or without laminectomy, occipitocervical fusion, foraminotomy in disc excision from the dorsolateral aspect, and biopsy or drainage of the body of C1 and C2 from the pharynx.

For those who are interested in disability evaluation they will find that section four of the book contains information which will help in reaching conclusions as to the amount of disability present in the injured person. The reading of this particular chapter and mastering it will prove helpful in avoiding embarrassment in litigated cases.

The last section deals with athletic injuries. In this section many of the injuries which are peculiar to athletes are discussed together with the mechanism that causes them and the methods used by the authors in their prevention and treatment. This particular chapter should prove of interest to the physician or surgeon who is a high school or college team physician.

I recommend unreservedly the reading of the book because it is not only well written and interesting, but because it contains a wealth of valuable information which should prove of value both to the established orthopaedist and to young physicians and residents who are interested in orthopaedic problems and traumatic surgery. In addition, the book is exceptionally well illustrated.

A. A. SAVASTANO, M.D.

HANDBOOK OF MEDICAL TREATMENT
edited by Milton J. Chatton, M.D., Sheldon Margen, M.D. and Henry Brainerd, M.D. Lange Medical Publications, Los Altos, Calif., 1960. Seventh ed. $3.50

This is the latest edition of this excellent handbook which is revised every two years. It is truly a handbook, measuring seven by four inches, and may be easily carried in a coat pocket or the physician's bag. Although it runs to over 570 pages, the print is sharp and, because of its concise and direct style, it reads easily.

The first four chapters are concerned with the medical aspects of medical management, including dietetics, nutrition, and fluid and electrolyte therapy. The discussion of acid-base regulation is outstanding, and the many clinical aspects of this are outlined. The changes in extracellular and intracellular fluid and electrolyte concentrations are described simply and clearly in terms of treatment of the seriously ill patients. This section of the handbook would be a great help in the middle of the night when the medical resident is off call and the hospital biochemist is not available, and the diabetic patient is becoming more acidotic and comatose.

This handbook then gives brief descriptions of diseases of the different systems with the approach to their treatment. Drugs are discussed by trade names, and there are tables describing the actions and side effects of many of the latest medications. Certain sections, such as those on endocrine diseases and the blood and lymphatic system, are outstanding.

The section on psychiatric disturbances — so common in medical practice — seems to me to be too brief and superficial. Also, the binding of this book is light, and one wonders how well it will stand up to the vigorous use which this text should get.

Why doesn't some enterprising concern contract with the physician to deliver the new edition of this kind of text automatically with each new publishing? Nothing is more vexing than to find that the available text is just too old to furnish recent specific information when called upon to do so.

JOHN A. DILLON, M.D.

THE WASHINGTON SCENE

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The G.A.O. further recommended that "physicians be required to certify on each claim that the amount billed does not exceed the physician's normal fee for the medical care furnished."

The army disagreed, saying that it believed "the present contracting concept is the most suitable to meet the requirements and is in the best interests of the government."

The A.M.A. noted that it had held from the outset that "fixed fee schedules would result in a more expensive program than if physicians were permitted to charge their normal fees."

Fixed fee schedules call for some fees above some so-called normal fees and others below average fees, the A.M.A. said, "physicians tend to 'balance out' by using fees listed in the fixed fee schedule."

Medicare was started December 7, 1960. During the first four years of the program, $130 million was paid to civilian doctors and $133 million to civilian hospitals for care of 1.1 million military dependents. Maternity cases accounted for about half the total.

Medicare has asked Congress for $73.2 million for the fiscal year 1962 beginning this July 1. This is a $6.9 million increase over Medicare's current budget. The increase is needed, Medicare said, because of more military dependents eligible for the program's benefits and increases in the costs of services.

Scanning the Medical Literature . . .

ABSTRACTS FROM PAPERS WRITTEN BY RHODE ISLANDERS

DEMYELINATING ENCEPHALOMYELITIS IN A CASE OF TETANUS TREATED WITH ANTITOXIN. Harold W. Williams and Francis H. Chafee. New England J. Med. 264:489, 1961

The finding of multiple pinpoint perivascular demyelinative lesions in the white matter of the brain of a patient who had clinical tetanus provoked interest in the possible relation to tetanus antitoxin which he had received. The literature was reviewed. Perivascular demyelinization is known to be a rare complication of measles, rubella, and scarlet fever. It is seen rarely after immunization against smallpox and rabies, and is known to occur after the administration of tetanus antitoxin. In experimental allergic encephalitis a characteristic perivascular encephalomyelitis is obtained after the injection of myelin, a substance normally found in brain tissue. The perivascular lesions are quite similar to those resulting from measles and smallpox immunization as well as to those described in our patient. This response to many stimuli is best explained as an allergic reaction. Our patient also demonstrated urticaria and angioedema from the eighth through the eleventh day of his illness which was impressive since the neuropathologist, unaware of this clinical reaction, independently dated the generation of the perivascular lesions as occurring by the ninth day, or four days before death. The authors conclude that this allergic response to tetanus antitoxin may occur more often than has been recognized. The uncritical use of tetanus antitoxin should be curbed.

HERPES SIMPLEX. Method of Arthur B. Kern. In: CURRENT THERAPY—1960. Edited by Howard F. Conn. W. B. Saunders Co., Phil., 1960. P. 466

The initial infection of herpes simplex occurs usually between two and five years of age. In most instances this goes unrecognized but in a small percentage of cases it is accompanied by severe local and systemic manifestations. Many clinical entities including acute gingivostomatitis, acute vulvovaginitis and generalized herpes simplex are manifestations of the primary infection.

Treatment of primary herpes simplex is symptomatic, no specific therapy being available. Measures include compresses with Burow's solution and colloidal oatmeal baths to hasten the healing of cutaneous vesicles, antibiotic ointments for secondary infection, in the more severe cases systemic antibiotics to prevent secondary infection and parenteral fluids to prevent dehydration and acidosis, and local anesthetics for ulcerative oral lesions. Steroids are contraindicated.

Following subsidence of the primary infection the virus remains dormant within the tissues. Under certain conditions it may be activated to produce recurrent herpes simplex. This manifests itself most frequently on the skin of or about the lips although many other areas may be involved.

Treatment includes Burow's solution compresses to induce drying of the vesicles and an antibiotic cream to prevent secondary bacterial infection. Steroids are contraindicated. Prevention of recurrent attacks involves first, elimination of all known aggravating factors and second, multiple smallpox vaccinations.

Excerpts from the *Preface on Doctors* by GEORGE BERNARD SHAW, written for *The Doctor's Dilemma*

The following were penned in 1911, a generation before socialized medicine had entered the public awareness.

1. Nothing is more dangerous than a poor doctor; not even a poor employer or a poor landlord.
2. Of all the anti-social vested interests the worst is the vested interest in ill-health.
3. Remember that an illness is a misdemeanor; and treat the doctor as an accessory unless he notifies every case to the Public Health Authority.
4. Treat every death as a possible and, under our present system, a probable murder, by making it the subject of a reasonable conducted inquest; and execute the doctor, if necessary, as a doctor, by striking him off the register.

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ABSTRACTS

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5. Make up your mind how many doctors the community needs and keep it well. Do not register more or less than this number, and let registration constitute the doctor a civil servant with a dignified living wage paid out of public funds.
6. Municipalize Harley Street.
7. Treat the private operator exactly as you would treat a private executioner.
8. Treat persons who profess to be able to cure disease as you treat fortune tellers.
9. Keep the public carefully informed, by special statistics and announcements of individual cases, of all illnesses of doctors or in their families.
10. Make it compulsory for a doctor using a brass plate to have inscribed on it, in addition to the letters indicating his qualifications, the words, "Remember that I too am mortal."
11. In legislation and social organization, proceed on the principle that invalids, meaning persons who cannot keep themselves alive by their own activities, cannot, beyond reason, expect to be kept alive by the activity of others. There is a point at which the most energetic policeman or doctor, when called upon to deal with an apparently drowned person, gives up artificial respiration, although it is never possible to declare with certainty, at any point short of decomposition, that another five minutes of the exercise would not effect resuscitation. The theory that every individual alive is of infinite value is legislatively impracticable. No doubt the higher the life we secure to the individual by wise social organization, the greater his value is to the community, and the more pains we shall take to pull him through any temporary danger or disablement. But the man who costs more than he is worth is doomed by sound hygiene as inexorably as by sound economics.
12. Do not try to live forever. You will not succeed.
13. Use your health, even to the point of wearing it out. That is what it is for. Spend all you have before you die; and do not outlive yourself.
14. Take the utmost care to get well born and well brought up. This means that your mother must have been a good doctor. Be careful to go to school where there is what they call a school clinic, where your nutrition and teeth and eyesight and other matters of importance to you will be attended to. Be particularly careful to have all this done at the expense of the nation, as otherwise it will not be done at all, the chances being about forty to one against your being able to pay for it directly yourself, even if you know how to set about it. Otherwise you will be what most people are at present—an unsound citizen of an unsound nation, without sense enough to be ashamed or unhappy about it.

* * *

(*Postscript,* 1930) During the years which have elapsed since the foregoing preface was penned, the need for bringing the medical profession under responsible and effective public control has become constantly more pressing as the inevitable collisions between the march of discovery in therapeutic science and the reactionary obsolescence of the General Medical Council have become more frequent and sensational.

Dodd, Mead and Company, New York,
1941 Edition

SPORTS INJURY CONFERENCE

MONDAY, SEPTEMBER 11

BEFORE AND AFTER LISTER

(Abstracted from *Selected Papers and Addresses*, by WILLIAM W. KEEN, M.D., published by Geo. W. Jacobs & Co., Philadelphia, 1923)

"In our Civil War Duncan quotes the figures of Fox, which are 'the latest revised statistics and are all larger than those of the Medical and Surgical History of the War.' The average strength of the Union Armies was 806,755, and the deaths 359,528, of whom 67,058 were killed in battle and 43,012 died of wounds. This gives a battle death rate of 33 per 1,000 per annum. The disease death rate was 65 per 1,000 per annum. The case death rate from disease was only 3.4 per cent, a very low figure.

"I can testify to the excellent condition of the Civil War hospitals, of which I saw many, but only in the East. When I say 'excellent condition' it must be with the reserve that we knew nothing as to bacteriology, which did not exist, nor of infection, which was utterly unknown as to its causes and prevention. The general sanitary conditions, and by this I mean shelter, ventilation, cleanliness, good food, as good nursing as intelligent orderlies could give, etc., were all excellent. But the surgical conditions as we *now* know were simply dreadful. Practically every wound suppurated, and in summer I have seen many wounds swarming with squirming maggots as large as chestnut worms — disgusting, but fortunately, not especially dangerous.

"In my *Surgical Reminiscences of the Civil War* I have given many statistics taken from the official Medical and Surgical History of the War, a few of which I will reproduce that you may see what blessed conditions you 'free born' men have inherited. Pyemia (blood-poisoning) was one of our worst scourges. There were 2,818 cases, and of these only 71 recovered, a death rate of 97.4 per cent. Few of you probably have seen even one such case. I have given a matter-of-fact description of it in my *Surgical Reminiscences*, but if you wish to see it sketched by a master's hand read that most touching and beautiful of all medical stories I know — 'Rab and his friends,' by dear old Dr. John Brown, of Edinburgh. He vividly paints the sudden change in the wound, the pulse, the eye, the mind, on and on, worse and worse, until 'that *animula, blandula, vagula, hospes comesque* was about to flee.'

"Tetanus had a mortality of 89.3 per cent. Of amputations at the hip-joint 83.3 per cent died. Trephining had a mortality of 61 per cent. Even of ligations of the femoral artery, 374 in number, 281 died, or over 75 per cent. Of 2,235 cases of secondary hemorrhage, 61.7 per cent died. Hospital gangrene, of which there were several hundred cases, had only a mortality of about 25 per cent, because we early learned the correct though empirical treatment, viz., the application of the actual cautery, pure bromine, strong nitric acid or similar destructive agents which killed the germ."

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLIV JULY, 1961 NO. 7

The Twentieth Charles V. Chapin Oration . . .

THE CHANGING SCENE IN MEDICAL EDUCATION AND PRACTICE*

ALEX M. BURGESS, M.D.

The Author. *Alex M. Burgess, M.D. of Providence, Rhode Island. Director of Professional Education, Miriam Hospital, Providence, and Memorial Hospital, Pawtucket; Area Consultant, Veterans Administration; Secretary-Treasurer, Association of Hospital Directors of Medical Education; Vice-Chairman, National Committee for Resettlement of Foreign Physicians; Former member and Vice-Chairman, Joint Commission for Accreditation of Hospitals; Former member, American Board of Internal Medicine; 2nd Vice-President, American College of Physicians; 1953-54; Past President, New England Diabetes Association, Providence Medical Association, and Rhode Island Alpha of Phi Beta Kappa.*

Man roamed the forest barefoot
But now wears leather boots
And when he kills his neighbor
He takes a gun and shoots
It really makes one wonder
Which way he evolutes
He really is the same old man.†

TIMES HAVE CHANGED but man has remained essentially the same. His fears and his worries are still with him. He faces danger, illness and the thought of death about as he always has. It is a question as to whether in courage, in fortitude and in carrying on his affairs generally, he has made any progress whatever — or has retrogressed. Progress of course involves change — but change, the continuous change of our changing times is an admixture of progress and retrogression. In our darker moments those of us who have watched for a half century the changes in national and community life and in American medicine are often too impressed with the retrogressive features of the times as we fatuously long for the "good old days." Progress we all recognize, but many of us can sense also the retrogression. We shall consider both of these aspects of the present day scene in the field of medicine with especial reference to medical education and medical practice in the United States.

*Delivered at the 150th Annual Meeting of the Rhode Island Medical Society, at the Medical Library, Providence, Rhode Island, on May 2, 1961.

†(*Adventures of Pithecanthropus.* Anon.)

As this presentation is primarily for the purpose of honoring the memory of Doctor Charles V. Chapin, whom we may call the greatest physician that Rhode Island has produced, it is well to recall his relationship to medical education. With his epoch-making studies in the transmission of infections we are all familiar — studies by which he taught the whole world. Perhaps we are not fully aware, however, that in the more conventional sense Doctor Chapin was a teacher. He served as professor of physiology at Brown for ten years beginning in 1886 when he was thirty years old. He was lecturer at Harvard Medical School in 1909, at the combined school for health officers of Harvard and the Massachusetts Institute of Technology from 1913 to 1922 and at the Harvard School of Hygiene from 1923 to 1935. He was indeed a teacher, and I remember well the remark of my uncle, Doctor George A. Sargent of Boston, when as a student I accompanied him to a meeting at which Doctor Chapin spoke. "He is ten years ahead of us all" said my uncle "and he is teaching us a great deal."

Medical Education in Chapin's Era

Let us look, then, at Medical Education and at medical practice as it was in the days when Doctor Chapin first taught at Harvard, 1909, and at what has happened since then in these two closely related fields. In the year 1909 I was a senior medical student at Harvard Medical School. Most of us who have been active in the medical field during the past fifty years can view the medical scene in perspective. Doubtless no two of us have come to exactly the same conclusions, but I believe that on the whole we would be found to be in agreement. I shall therefore set forth my own opinions limiting my discussion to the field of medical education, particularly graduate and postgraduate education, and to medical practice. I shall try to tell you what I have seen, what now I see and what I anticipate.

I shall not spend much time in discussing undergraduate education in the medical schools. Here the changes that have taken place have been occa-

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sioned (for the most part) by such great advances in so many directions that it is well nigh impossible for an individual to do more than get a general view of the scientific basis on which the application of medical treatment rests. Four years of medical school and a year of internship was an adequate preparation for practice in 1910. Now it is merely a beginning, and even if one intends to remain in general family practice a minimum of two years graduate training is recommended.

Beginning, then, with medical education, it will be recalled that in 1910, the year of my graduation from medical school, the famous report of Abraham Flexner appeared with the resulting elimination of most of the really substandard medical schools. The work of these schools is not familiar to me and I am not competent to discuss them. In that day a small number of graduates of even the best medical schools went directly into practice, but most of them served in internships of from one to two years duration. Some of these were "straight" and some rotating. Appointments (as a rule) were staggered so that as he neared the end of his service the senior intern, "house physician" or "house surgeon" as he was called, was given a rather high degree of responsibility and occupied essentially the position now held by the chief resident. As the years have gone on and as diagnostic and therapeutic techniques and procedures have become more refined and numerous, and the mass of information needed to understand them and to put them to use has become so very extensive, the years of training have increased. To prepare a man to practice surgery or internal medicine nowadays a period of time is required in which his predecessor of fifty years ago would have come to consider himself rather a seasoned practitioner. All this extension and refinement of training and the great advances in medical knowledge on which they are based has of course resulted in more effective treatment and the extension of many lives that would have been lost because of diseases which now are curable. We are all very familiar with these facts. They indicate progress — great progress. What of retrogression? Has there been any? The answer is yes. It is certainly not great in comparison with the advances but most of us who were students in the old days are conscious of it and are trying to prevent it. Where are the Fred Shattucks, the George Sears and the William Oslers of the old days? True, many of their medical descendants are still on the job, trying to preserve and pass on their clinical virtues, but the task is well nigh impossible. Too often ward rounds and conferences are, of necessity, so filled with a discussion of the results of many and varied laboratory investigations that there is not really time to give attention to the patient himself, his fears, his worries and the details of his physician findings. The eye that can read the colorimeter and interpret the electrocardiogram often fails to notice physical asymmetry, visible peristalsis, the minor variations in muscle spasm or the like. The ear that hears the routine story of previous illnesses and operations often is unable to detect the tremor in the voice or the terror that the new experience of being a hospital patient may have engendered. Both in being able to realize that his unfortunate patient may be a fellow who needs a friend more than a sedative and to detect by the use of trained observation in preference to laboratory tests the real nature of his patient's condition, there has been a retrogression, a loss of competence that is rather striking. One has only to watch the average recent graduate carry out a physical examination to realize that percussion, for example, is becoming a lost art, and dependence on the laboratory, X-ray and other aids have so undermined the confidence of many a young physician in his ability to see and hear and feel that without these mechanical aids, he hesitates to form an opinion. Not long ago in participating in the oral examination of the Board of Internal Medicine I had completed my session with a young candidate who seemed to me to have a most complete grasp of modern medicine and to whom I was ready to accord a very good grade. To my astonishment my colleague who had examined the physician on his study of another patient and who is a most distinguished internist who has himself introduced biochemical diagnostic procedures of great value said to me, "I am sorry but I cannot pass this young man." When I stated my good opinion of the candidate's grasp of medicine my co-examiner said, "Yes, I know. I am sure he knows more medicine than you and I will ever know, but he missed the enlarged and nodular liver that was the most important finding in the patient he studied for me." "In my judgment," he went on to say, "when you can really get the feel of a liver it is worth more than a whole page of laboratory results."

The Specialty Boards

And what of the specialty boards? What has the whole system of specialization and certification done to medicine. Specialization has, of course, been necessary because of the vast accumulation of medical facts and techniques which have made it impossible for any one individual to be really proficient except in a limited field. Board certification, introduced to give the public a means of being certain that a physician who claims to be a specialist is really qualified in his field, has, perhaps unfortunately, been used for other purposes and is not an unmixed blessing. On the whole, I believe, its effect must be judged to have been favorable when one realizes that it has caused thousands of young physicians to continue to study and perfect themselves

and has thus made them able to give better service to the sick. The boards have certainly raised medical standards.

What of the other side, the liabilities of the situation? These too are very real. The personal tragedies of repeated failures on the part of earnest and conscientious physicians are regrettable. Furthermore, in examining large numbers of candidates by the methods that are necessary because of these very numbers, mistakes are inevitable. Many of us have seen instances in which we, with an intimate knowledge of our colleagues and their work, have recognized that it is a superior individual who has failed while another physician, definitely his inferior, has been certified. For this reason (in my opinion), it is wrong for a hospital to substitute the label of board certification for its own good judgment in considering the physicians of its own staff for advancement. Despite these drawbacks, as I have said, it is my belief that the over-all effect of the activities of the boards has been a favorable one. There are now nineteen boards. The creation of more and more boards for the certification in more and more subspecialties could easily result in the deterioration and collapse of the whole system.

What, then, has been happening during these years since the time when there were no boards and a physician certified *himself* as a specialist — basing this on his special studies — and succeeded, if he could persuade the public and his colleagues of his competence? In those days the great majority of physicians who took up specialty studies did so after a period of several years in general practice, although the beginning of residency training in the modern sense had been established in some of the larger medical centers. With the creation of more and more specialty boards, beginning with the American Board of Ophthalmology in 1916, the picture has been progressively changing. What do we now see? At present the average young graduate who intends to specialize makes a choice of the specialty in which he wishes to spend his professional life and works to complete the training indicated by the appropriate board which has determined minimum standards of time to be spent in council-approved programs. This appears to be a distinct limitation on the freedom of the individual, and in a sense it is, but it results in better work by better trained physicians and is a real protection to the patient, even though, regrettably, it may deter the occasional talented physician from traveling an unorthodox route and acquiring special skills and points of view. Furthermore, the mass of information and extensive supervised experience that are required in 1961 before a physician can be considered competent in a special field make necessary a system under which he can perfect himself, and both the public and his colleagues can be assured that he has done so.

The situation as we see it at present, then, is about as follows: A large group of graduates are taking up residency training in the various specialties. These are the figures:

Approved residencies: 31,818 in 1298 hospitals. These residencies offer training in twenty-eight different specialties.

Internships: 12,887 in 859 hospitals. 814 programs are general rotating, 32 are "mixed" and 241 "straight." A large number of graduates who are serving in these internships, as required for licensure, go into general practice. Of those who have followed this plan it is estimated that about 20% have joined the American Academy of General Practice which has made very creditable efforts to raise the level of work in this field towards the status of a specialty. This they have done by requiring extra training. It is understood that a minimum of two years' graduate work in a hospital will be required, and afterwards its members will have to show evidence of continued postgraduate educational effort to maintain their membership. We have, then, the division of the profession into the certified specialists and those who, though many of them are very competent in special fields, and many are keeping up to the standards of the Academy of General Practice have not obtained nor are training for the badge of certification and are definitely working in the field of general practice. Before we consider what this division means and will mean in the future let us think of the role of the modern hospital.

Expansion of Hospital Services

Many of us who are still active in 1961 can remember seeing abdominal operations carried out by competent surgeons in private homes. The operation may have been performed on the kitchen table, with almost any young practitioner or student "pouring the ether." This was a long time ago, a time when the most serious illnesses and most obstetric patients were well cared for, according to the standards of the day, in the houses in which they lived. Contrast that picture with the present situation. Now almost all severe illness must be treated in the hospital because detailed diagnostic and therapeutic procedures require elaborate apparatus and teamwork by many individuals. The care of serious illness, then, requires hospital care by experts. Let us consider what this means in the matter of hospital staffing and the division between specialists and generalists to which I have referred.

The small community hospital still appoints to its staff graduates of its one-year rotating internship who go into general practice in the community, *providing there are no certified specialists* applying for the same positions. In larger community hospi-

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tals and those affiliated with universities the label of specialty certification is in almost all cases a requirement, although in senior positions there are still a few superior physicians who have not felt the need of obtaining certification and who are leaders and teachers of junior men. New applicants, however, if not certified specialists or in line to become certified, will receive little consideration.

What then can we expect as this trend continues? Will we not, of necessity, witness a division between the hospital staff members, the team of techniques and tests, and the family doctors, the personal physician practitioners or, as we might say, between the sons of the science and the artists of the art of medicine? Will either group be considered as second-class doctors? If so, which? Neither, it is to be hoped. If physicians do become divided in this manner, as happened in England and in other countries, there is no reason, whatever, to accord the higher prestige to the hospital group, as has been the case elsewhere. A distinguished professor of medicine recently told me that in his judgment the most important function of the highly trained internist should be the diagnostic study of individuals in their homes or in his office referring them to the hospital for the technical procedures needed for further investigation and treatment. Such a study by the internist would of necessity involve the acquisition of a clear comprehension of the patient as a person, his fears, his worries and all phases of his personal problems. Such a physician could be a liaison person between hospital groups and family doctors. But these family doctors, themselves, will need a good general grasp of scientific medicine, especially in the matter of diagnosis, and their opportunity to know people and to help them should make their work most satisfying. On the other hand there will always be a necessity for the technical experts on hospital staffs to practice the art to some degree at least, dealing with their patients as *people* with fears, frustrations and forebodings.

High Degree of Understanding Needed

A high degree of humanity and understanding is needed by all physicians. Unfortunately one occasionally notes even now, when hospital work still is carried on principally by physicians in private practice, that ward rounds with a group can be very damaging, and thoughtless remarks can destroy the degree of confidence and morale that may have been most difficult for the patient to achieve. I have felt that at times it has been more harmful to a patient to say the wrong thing to him than to give him the wrong medication. One must deplore the "determinized attitude toward the patient" described by Doctor Sol Weiner of New York in an address in which he quotes a colleague as saying, "between the physician and the patient there has become interpolated a third entirely mechanical thing — the apparatus." Despite this intrusion there is certainly no reason why both the family and the hospital doctor should not practice *all* phases of medicine with the emphasis in the work of the family practitioner on the art, and of the hospital doctor on the science.

This division of function between hospital and family physician may not develop but at the present time it seems most likely. It might well result in an improvement in patient care in the hospital for it would leave the hospital staff members free to reach a very high degree of technical excellence in narrow fields, kidney disease, thyroid disorders, hematology, diabetes and the like, without making it necessary for them to spend their time in studying the broader fields of medicine, while the general internists and family doctors could be familiar with this work without spending their time on learning scientific details and techniques useful only in special fields in the hospital. Under these conditions the two groups could meet in conferences and case discussions at which each would learn enough of the work of the other to keep them both up with the general progress of medicine.

Although "organized medicine" in this country has stated that the American people receive the best medical care in the world, this is open to question. In many countries, England and Israel for example, the average citizen who is ill and is taken to the hospital is placed under the care of highly selected experts, while in America it is possible for him to be attended in many hospitals by a general practitioner who has hospital privileges and who, from a technical point of view, may be distinctly less able to cope with diagnostic and therapeutic problems than are his more highly trained colleagues. The division of the profession, then, which we have been discussing, might well result in more competent care of the hospitalized patient. Doctor Osler L. Peterson in his article titled *How Good is Government Medical Care?* puts it this way, "The Scot or the Norwegian who enters a hospital in his country can do so with the assurance that the surgeon or physician who cares for him is well trained and well selected for his post. The American who enters a hospital must depend upon his own imperfect judgment of a doctor's qualifications."

Development of Group Practice

The "solo practice" of medicine of a half a century ago is certainly out of the picture. The doctor cannot possibly be all things to all men. Group practice, formalized or more or less informal, has become a necessity even in small communities. Can the practitioner of the future continue to be a family physician and a hospital expert as well? Is the hand-

writing on the wall? Already, as we know, many hospitals are appointing full-time salaried chiefs of services. Is this a step toward relegating the attending physicians to roles in the hospitals which can be considered minor and likely to be more so as time goes on? This would be hard to deny.

In the field of academic medicine the trend is already firmly established. As in many other university departments, so in medicine, achievement in research in extremely specialized fields is required of those who aspire to top faculty appointments. In the field of internal medicine, for example, as Doctor David D. Rutstein points out, "Demonstrated competence in the basic sciences — particularly in one of the sub-specialties of biochemistry — is almost a prerequisite. Ability to manipulate the gene, the hemoglobin molecule, or an enzyme system is prized far above skill in management of a patient with a complicated disease. Those whose competence is limited to clinical research and teaching are likely to be passed over. A modern Sir William Osler, for instance, could not win appointment today as head of a department of medicine in an American medical school."* Our medical leaders are excellent scientists but often we must admit, they are mighty poor doctors and sometimes inadequate teachers as well.

In this situation Doctor Rutstein has made an interesting suggestion. He proposes that the "medical school set up two divergent courses of study, one for medical research workers and specialists, and another for the practicing family physician." Should this be done the division of medicine along the lines which I have indicated would certainly take place.

Progress and Retrogression

The advisability of such a division seems questionable. Even in the most highly specialized services in the best equipped university hospitals, the work of the scientifically competent but emotionally bungling professor *must* be tempered by the real compassion and understanding that marks the true physician, or his teaching is inferior. Treating human beings on a biochemical level only is a halfway measure that falls far short of good therapeutics. It seems clear that the present trend will have to be altered and a place for the *real doctor* will have to be maintained even in the Ivory Towers of the profession.

There is another phase of the work of the present-day physician which I wish to discuss. In the field of pharmacology and therapeutics we have seen the development of powerful and effective drugs of various sorts, insulin, sulfonamides, antibiotics, vitamins and hormonal preparations and others, that have revolutionized therapeutics. Wonderful success has been achieved in controlling many serious diseases as we are all well aware. "Wonder drugs" indeed! But as we also know every medicament capable of great good is, if improperly applied, also capable of great harm. For the development and perfection of many of these the great pharmaceutical industry deserves credit. From its research laboratories have come excellent new products which have been of the greatest value to humanity. Progress! Great progress indeed! Let us, however, not stop here but let us look at the other side of the coin. Competition and commercialism have dimmed its brightness. Expensive brochures and persuasive detail men have pushed the sales, and we see the crossroad's doctor employing the new drugs freely in treating his patients on the basis of sales propaganda in what is really a most reckless manner. This is far beyond what the experts in university departments where these very drugs are being studied would dare to attempt — the fools of practice rushing in where the angels of research must fear to tread. This is retrogression. Then too, there is the almost hopeless confusion of trade names and the fact that the A.M.A. council had, for a time, apparently abandoned its proper control of the situation. Retrogression again and reform urgently needed — and already measures of correction are under way.

Another example of progress and retrogression is seen in the educational programs of community hospitals. This is of great importance not only because hospitalization has become so generally necessary, but also because the non-university affiliated hospitals have so increased in number and capacity that they now admit over seventy-five per cent of people who are treated for acute medical or surgical conditions in hospitals in the United States. The increase in the number of approved programs established in community hospitals as a result of the demand created by the return of young physicians to private life at the end of World War II and the Korean War was definite evidence of progress. The *decrease in demand* for appointment in these programs on the part of American graduates that later occurred, when there was no longer a large group of those who had been in the armed services to deal with, and the *necessity* to fill the positions with graduates of foreign medical schools, many poorly trained, was retrogression. Progress is again evident in that in the past few years most of these community hospitals have greatly improved their programs. Many have appointed directors of medical education. Furthermore, the Educational Council for Foreign Medical Graduates now screens all physicians from medical schools outside the U.S.A., Canada and Puerto Rico. With the protection of the public and the hospitals that this

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agency affords, we have a situation which will be favorable, providing enough foreign graduates to fill the needs of the community hospitals are available. As we all know there are more than four thousand approved internships in excess of the number of American graduates. While some of these are substandard and should be improved or eliminated, most of them are good. The maintenance of a house staff in a hospital with a good educational program means not only a service to these physicians in training and to the foreign countries to which they will return, but, what is more important, better work on the part of the staff members who are their teachers, for it is always the teacher who learns the most, and, *most important of all*, better care of the patient.

In this presentation on medical education and practice many important factors which affect the situation can be considered but briefly. The much discussed cost of hospital care, for example, is so significant, that it must indeed be mentioned although to deal adequately with this subject is beyond my competence and the time at my disposal. It seems clear that something must and will be done. Not only is the public showing great and understandable concern, but, as the "consumer" of medical services, it obviously intends to insist on more efficient planning and co-operation between physicians and hospitals, and sufficient public control of the situation so that its interests can be protected.

Duplication of Equipment and Services

One reason for excessive hospital costs is the duplication of expensive equipment and specialized services in several hospitals in one community, where such facilities in one of the hospitals would fill the need. We see this in Providence. What an opportunity for co-operative planning we have in Rhode Island! If the various special procedures, such as, for example, the expensive organization and equipment required to study patients who may need cardiac surgery and to carry out such surgery, could be confined to one or two hospitals, rather than having several of them competing with each other and interfering with the full development of competence on the part of any group, better work at less expense to the public would result. The same holds for work with the artificial kidney and a number of other highly technical procedures. An equitable assignment of the development and operation of such projects to hospitals ready and able to undertake them and an agreement of other hospitals not to duplicate these efforts but to develop others as their share in the medical work of the state would be a wonderful achievement and a model for the whole country. Control of such division of labor would have to be through co-operative planning by the hospitals as a group. Political or government control would be worse than none, but could be forced on us if we make no effort of our own. I'm afraid a medical millennium, even in Rhode Island, is a long way off.

As a matter of fact this duplication of specialized and expensive procedures is but a minor factor in raising the cost of hospitalization. More important is the cost of the equipment that is now necessary for the accurate diagnosis and effective treatment of disease and the necessary co-operation of many experts. There is, however, a favorable aspect to the situation — the treatment of disease is much more effective than formerly, more patients get well and most of them are returned to their homes much sooner than used to be the case.

However, the cost of being ill and hospitalized is very high and has made necessary prepaid insurance. We know that many powerful groups are taking this matter very seriously. Not only the voluntary Blue Cross and Blue Shield and other forms of prepayment for care by *independent* physicians, but various organizations for the furnishing of medical care by *full-time* doctors such as the chain of hospitals operated by the United Mine Workers, the Health Insurance Plan of Greater New York (H.I.P.) and others, are in operation. This may be only a beginning.

Should it become evident that the public is going to demand general compulsory insurance by government, despite all its well-recognized disadvantages, it will also be true that if the medical profession wishes to have any part in planning it must be willing to co-operate. A desperate last ditch struggle, an uncompromising opposition to change, can only result in a complete loss of any chance to have a hand in shaping the future of medical practice. Let us not forget the results in England where the general practitioners presented bitter and complete opposition to the establishment of the National Health Service and have been most unfavorably situated ever since. The forces that will demand changes are powerful and their demands are not entirely without reason. If the changes that appear inevitable can occur by evolution and if the medical profession can give co-operation and guidance rather than presenting a front of bitter and unyielding opposition the end result will not be bad. It is true that the doctor's freedom of action may be somewhat curtailed but the patient, even though his choice of physician may not be entirely free, will in many instances be better served.

There is one rather dark cloud on the horizon. The number of top-grade students entering medical school is diminishing. With the changes that are coming, the possibility of some government control, the high cost of medical education and with the rash of public criticism of doctors and hospitals that has

recently been fashionable, it appears probable that it may be difficult to attract the best of our youth into the profession. At this point, if I may again take a long look backward, I can assert that in my judgment this criticism of the medical profession comes at a time when medical practice is carried out on the highest ethical plane in history. To students the attractions of engineering in its various divisions with its promise of relatively prompt advancement to higher income status is probably a potent factor at present, but this situation cannot last as the engineering ranks will in time be filled. Furthermore, plans are being made to give scholarships and loans to medical students which should be very helpful. The present situation must be a temporary one for human beings and their basic health needs do not change. The demand will eventually result in an equivalent supply of those young people whose abilities and ideals lead them to undertake the physical and mental care of their fellow men and the soul satisfying scientific studies of their ailments.

What Lies Ahead?

And now, as we have viewed the present scene with both a backward look at the conditions from which it has developed and an occasional attempt to obtain a glimpse of the future, let us briefly review the highlights of what we have discussed with special emphasis on our guesses as to what lies ahead. First, and perhaps most important, what can we say of the practice of medicine both within and outside of our hospitals? That a change is taking place is clear. Detailed and specialized knowledge and techniques mean hospital personnel with more competence in narrowly specialized skills. The establishment of more and more full-time staff members who must give their whole attention to the study of hospitalized patients, except for such outside consultations as their individual skills make appropriate, is already taking place. I anticipate that this trend will continue and the cleavage between the hospital technical experts and the practitioners outside the hospital will gradually become more definite and complete. From the point of view of keeping the whole profession well in touch with the progress of medicine this trend will have to be controlled and a means found to keep all physicians who are in private practice fully conversant with medical advances, or we will have a definite retrogression in the quality of patient care in our communities. The family physician must be kept from becoming a second-class doctor, as has occurred elsewhere in the world.

In this matter of continued postgraduate education I anticipate further development of the work of the Academy of General Practice and perhaps even certification in this field as a recognized specialty. In the specialties now recognized, board certification will doubtless be continued, but with the establishment of more and more full-time hospital positions for physicians there may be places for fewer specialists and the boards may need to certify fewer. The length of training for the specialties will not be reduced, but one must remember that the physician who is putting in years of work in approved residencies is not training for his life work, but *doing* it.

Among other matters which we have considered, the deluge of new drugs presented to the bewildered practitioner with confusing trade names and often with misleading sales propaganda presents a situation which must, and I believe will, be corrected. The use of well-chosen generic names which should be insisted upon in hospitals and more complete and careful control by medical authorities is, I trust, on the way. One cannot believe that the great pharmaceutical industry which has done so much for the health of the public can do otherwise than co-operate.

Another subject of paramount importance that we have mentioned is the development of the educational programs of community hospitals. Despite the set-back that some have received as the result of the diminished numbers of available foreign graduates, I am of the opinion that these hospital programs will develop and improve and that the hospitals will become more and more completely the educational centers for the profession in their areas. I believe that the diminution in the supply of physicians applying for training in their house staffs will be temporary and that the benefits to these interns and residents, to the attending staffs and to the public will be increased. For many years, I anticipate, physicians from abroad will desire American clinical education. With the protection of the public that is the main function of the Educational Council for Foreign Medical Graduates, I anticipate better days ahead in this most important segment of American medicine. Hopefully foreign exchanges will eventually become two-way in type and American graduates will be accepted at hospitals in Britain, on the European continent and elsewhere. With the development of a stable world situation, for which the whole world longs, this could take place.

As to the effect of the rising cost of medical and hospital care, made inevitable by the development of expensive techniques and equipment and public recognition of the need for prepaid medical insurance, one cannot escape the opinion that outside controls, even by government, may be forced on the profession. Should this situation arise, to salvage what is best of our system as we have known it and to have a hand in shaping what is to come we must, as the pugilists put it, "roll with the punch," accept-

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Presidential Address . .

THE THIRD PARTY IN MEDICINE*

EARL J. MARA, M.D.

The Author. *Earl J. Mara, M.D., of Pawtucket, Rhode Island. President, 1960-61, the Rhode Island Medical Society.*

THANK GOD that we in America still have the right of free speech and that "organized medicine" has never tried to limit the right of expression of opinion by any of its members.

We heard the opinion of an outstanding learned physician expressed here last night, and this morning we were once again given evidence of a biased press when it gave headline prominence to the particular statements that suit its fancy, and once again taken out of context.

I would like to remind you that on November 7, 1937, the NEW YORK TIMES published a list of 430 doctors who had "courage to rebel against organized medicine." It stated that these 430 doctors had made a medical declaration of independence. The principles and proposals of the Committee of 430 called for the recognition by the medical profession of the principle that "the health of the people is a direct concern of the government," and that a "national health policy directed toward all groups of the population should be formulated."

This declaration sounds familiar to all of us, young and old, and we are well aware of the fact that our honored speaker of last evening was one of two Rhode Island doctors listed in the NEW YORK TIMES as a signer of the so-called "medical declaration of independence."

At the time of the NEW YORK TIMES release rebuttal by medical societies was prompt and forthright. In a news item in the PAWTUCKET TIMES in the following week a statement was made by Doctors Charles Farrell, Robert T. Henry and Earl J. Mara referring to Doctor Burgess's reversal in his previously published statements regarding "socialized medicine."

Quoting from the PAWTUCKET TIMES, "The three Doctors pointed out that in the RHODE ISLAND MEDICAL JOURNAL of January 1937, in an article titled 'Progress in Private Practice — Is Socialization Needed?' by Doctor Alex M. Burgess, appear the following:

(I quote in part.)

"If then the work of the physician today under the system of independent private practice is not on the average so poor, if in fact he is doing increasingly better and more scientific work as the years go by, fulfilling, as he must, higher and higher technical requirements to be admitted to practice, and preserving as he does, the lofty ideals that are his heritage, one can hardly say that the profession of medicine is in a state of 'decline.'

* * *

"Anything which limits the free choice of his physician by the patient will be a step backwards, and anything which takes away from the physician the necessity of 'making good' in the eyes of his patient and of giving him his level best of attention and kindness as well as of technical skill, will be retrogression indeed.

* * *

"Let us mention only in passing the possibilities of gross injustice that are ever present under any sort of bureaucratic control and in this connection let us quote the words of another Englishman, the present Lord Chief Justice; 'The Treatment of the panel doctors under the national health insurance Acts is pure despotism.'

* * *

"... in view of the fact that in no group of independent individuals in our modern civilization is the profit motive less prominent and the need of socialization less urgent than it is in the medical profession."

The above quotes are intended to look in retrospect at the opinion expressed by Doctor Burgess in our own Medical Journal in 1937. The press did not give headlines to these comments of our honored speaker of last evening, at the time of their utterance.

It proved once again, to my mind, the doctor must be properly informed through the publications of his own society, and it further proves that "organized medicine" does not "gag" its members, but gives one and all an opportunity of expression.

*Presidential Address delivered at the 150th Annual Meeting of the Rhode Island Medical Society, at the Medical Library, Providence, Rhode Island, May 3, 1961.

However, it does reserve the right of rebuttal by its duly elected officers to speak for the majority of its members.

The Doctor and His Medical Society

The practice of medicine has proceeded a long way from the time of Hippocrates, and medical services are becoming more complex day by day.

The impression has been created too often, that a small group of administrators at the Chicago headquarters of the American Medical Association dictate in some magical way all of the policies that govern the entire practice of medicine. Too often, the news media of our nation categorizes the A.M.A. as something distinct and apart from the doctor in the various county and state groups.

Why do we allow this impression to continue and grow? We know that our local county medical association controls the practice in its community and governs the activities in its respective area for ethical medical service and progressive public health measures. I know that I applied for membership in my local medical society, and I considered it a great honor to be acceptable for membership. The certification of active membership in his district medical society is all the doctor needs to submit to join the state medical society, and notification of membership in good standing in the local and state organizations is all a doctor needs to be eligible for membership in the American Medical Association.

We know the process of organization, but we individually have not clearly told our story to our patients, to our friends, and to interested parties everywhere. Such a positive plan should be and must be arranged to clarify the misinformation.

Using the words "organized medicine" the cry from socialistic forces are heard on many fronts. They flood the news media available to the public with "venom" about "organized medicine." These groups have repeatedly indicated that the A.M.A. is an association or organization for doctors, but presumably not by doctors.

Recently I received a copy of the OIL, CHEMICAL AND ATOMIC UNION NEWS, and one-half the paper is devoted to discrediting the American Medical Association. Such captions as "How the A.M.A. Cracks the Whip on Your Doctor," "A.M.A. Old-Timers Starve Out Doctors Who Don't Play Ball" and "Committee Rigging by Old-Timers" are used.

Statements oftentimes attributed to "organized medicine," frequently come from the arm of medicine engaged in teaching, research, and administration. These brethren are often too far removed from the actual practice of medicine to issue authoritative opinion as to the policies of the practicing arm of medicine. However, working together and with the help of God, these arms of "organized medicine" have increased the life span of man twenty-two years since 1900.

In light of these facts we are obliged to review the efficiency of our own Medical Society. Our Medical Society is as good and as effective as we individually make it through our personal and individual communication with the public. We work collectively through the various Committees of the Rhode Island Medical Society to augment the efforts of the individual physician. The doctors of Rhode Island, through the Rhode Island Medical Society, have repeatedly demonstrated in increasing ways how vital a factor in community life our organization is.

It is true that many of our members, unfortunately, have not fully sensed the importance of service through the various committees of the Society. But to those many doctors who have given of their counsel, energy, and time throughout the years we are indeed indebted. I wish to commend, particularly, those devoted and dedicated physicians who have carried forward active programs during the past twelve months. It is by and through their efforts that the Rhode Island Medical Society becomes a "living organization," that gives far more to the welfare of the citizens of this state than any comparable group.

By way of example, consider the work of our child-school health committee which has met often to study and review school programs, to set up standards for health examinations of schoolchildren, and which has encouraged the adoption of sound practices by our various school districts. Or perhaps consider the public service of the diabetes committee with its Diabetic Fair and free testing programs for the dissemination of authoritative information regarding that illness.

The list of working committees is a long one, and the work accomplished has a tremendous impact upon the good health of the citizens of Rhode Island. No medals or awards are sought or desired by these committees, but it certainly redounds to the credit of the physician and to "organized medicine" as represented by the district and state medical societies with which they are affiliated.

To enumerate additional committee services and studies:

1. Problems of safety in industrial plants and protection of the interests of the worker injured on the job.
2. Consideration of vital decisions for the care and protection of those afflicted with mental illness.
3. Study and review both perinatal mortality and maternal health, which has resulted in the lowest maternal mortality rate in the nation for Rhode Island.
4. Support of effective highway safety controls and chemical tests to halt the drunken driver.

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5. Close observation and quick protestation where legislation is proposed that is inimical to the interest of the public.
6. Evaluation of the public assistance programs to aid the welfare recipient, and contribute so that he shall get the finest medical care available in our state. The dollar value contributions by the doctors of Rhode Island to the Welfare Program is a matter of public record.
7. Constant study of problems of medical care for the older-age citizen.
8. Development of standards for blood bank programs in our hospitals.
9. Preparation for adequate medical coverage in the event of community disaster.
10. Close alliance with all agencies in the health and welfare field.

These and many more are included in the activities of your Rhode Island Medical Society.

In addition to the afore-mentioned programs, the Rhode Island Medical Society, after tremendous studies and preparations, offered the people of Rhode Island a voluntary prepayment medical and surgical plan, known as "Rhode Island Medical Society Physicians' Service Corporation." From the day of its founding, devoted physicians gave, and are still giving of their time to give the best plan available in the voluntary prepayment field to the citizens of the state. At its outset the fee schedule was arranged and arrived at after considerable studying, and by concession on the part of participating physicians, which permitted service benefits for many people at a fee below the average fee charged for these services at that time.

The Rhode Island Medical Society Physicians Service has developed and expanded through the years and is second to none in this country. The success has been greatly due to participation of practically the entire membership and to the review of cases by an active Claims Committee. No other plan has, or in my opinion, will ever be able to offer service benefits to so many citizens of Rhode Island.

We must not, and shall not, stand on our record, however, but proceed to improve our plans for the common betterment of all citizens of Rhode Island.

All the programs that I have mentioned are possible because in this state, organized 149 years ago, on the premise that the medical art is important to the health and happiness of society, and through the years our predecessors and we have dedicated ourselves to the healing arts for the benefit of all citizens and not a favored few.

Intrusion of Third Party

All of these accomplishments have not been made without an increasing measure of interference and "heckling." A "third party" is involved in over 90% of physicians' services today.

Prior to World War II there was an occasional third party representation by private insurance carriers, but with the New Deal Era and with the advent of World War II, the impact of the third party on the physician-patient relationship soared to an ever-increasing high.

During World War II, wages were frozen, and fringe benefits came into being. The insurance industry, particularly voluntary prepayment plans, got a "shot in the arm," with labor seeking, and management agreeing to pay for medical and surgical care.

At the same time medicine was having its "face lifted" with the changing of the ratio of specialists to general practitioners, as the result of a liberal GI bill permitting postgraduate education.

Related services spurred on by the war effort produced and perfected many new therapeutic measures and operative techniques.

With this explosion of knowledge in science came a newer approach to the healing of the sick. The third party must be met on many fronts, in hospital administration, in office records, and in billing patients for services rendered. However, in spite of the increased pace and interruption, nowhere along the line did the doctor of medicine forget the heritage of his predecessor, who worked with such limited resources; rather, he has continued to comfort the afflicted, restore faith, hope, and health, and ease the mental anguish of patients' families. He has added, and continues to add, all the newer diagnostic and therapeutic measures to his armamentarium.

The interest of the third party has all but destroyed the privileged communication of patient and physician. Government agencies, OASI, VA, Welfare and Disability Compensation, insurance companies (private and voluntary) and union health and welfare programs require limited information to process claims. However, too often, personnel handling this information do not respect its confidential nature in the best interest of a patient.

Washington has continued to offer services to the public and judging from the bills already offered in Congress, this year will be no exception. Some of the services that are granted by Washington are not needed by, or demanded by the public. These give-away programs too often tend to destroy one of the finest character building mechanisms within the soul of man. They destroy initiative of many individuals who are our best workers and producers. Increasing tax structures have destroyed or are destroying man's desire to contribute to his neighbor in time of need. How often we hear, "let the government support the hospitals and clinics, and research in cancer, aging, heart disease, etc., . . . I pay enough in taxes."

In the relationship of man, everywhere in the world, where there has been regimentation the medical profession was regimented first. Doctors are too busy and dedicated to their duties to prevent regulation. It is my opinion that the third party will remain in the practice of medicine, but let it be the third party of common consent of physician and patient. Let it be the voluntary system and not the regimented type.

We, as a profession, must accept the stewardship of responsibility of total care or allow someone else to do it for us. It is not sufficient to cry No! No! No! A positive plan must be developed and offered within the framework of the voluntary system.

Finally, we must agree that it is not morally correct for society to neglect those in need. However, it has been suggested that the moral action of individuals be replaced by "collective morality." How can action be moral if it is induced by compulsion? I prefer to believe that the individual who, after being apprised of those in need, seeks to remedy the situation, insofar as possible, by loosening his own purse strings, is thinking and reacting favorably to a moral issue. Contrariwise, one who thinks only in terms of legislation to force everyone to take care of a problem, is reacting unfavorably to the same moral issue.

I would like to remind proponents of the regimented policies that from the time of Hippocrates one of the finest traditions of "organized medicine" has been to give medical care to those unable to pay. If proponents of government medicine are successful they surely must realize that this tradition will be destroyed and that the cost of this care will become the responsibility of the taxpayer.

Leadership must be fearless and support must be loyal in any plan of rebuttal. We must have positive thinking, develop a proper perspective and disperse factual information to afford us a proper sense of direction. The alternative is that we become bogged down in the "quagmire of rumors" that spawn fear and deplete courage. I would remind you that a winner never quits, and that a quitter never wins.

In conclusion, I would remind you that the term "organized medicine" is an honorable characterization here; for by your efforts as members of the ninth oldest state medical organization in this country we have completed a record of which you may be proud.

I commend you for your support and remind you that only in unity is there strength. All plans of regimentation will fall short of success if we stand united. We must push apathy and defeatism aside, and not consider these legislative programs as the beginning of the end, but rather the end of the beginning.

LESSONS
from the
HISTORY OF MEDICAL DELUSIONS

The lessons which are taught by the history of past delusions are slowly learned by the medical profession, and still more slowly by the community at large. In the progress of human knowledge medicine has not been disencumbered of error so rapidly as the other sciences have been. So little does it bear the character of an exact science, especially in its Therapeutics, and so prone are men to conjecture and theorize where they cannot know, that the errors of the past on this subject have very generally failed to guard effectually against errors in the future. The history of medicine, therefore, presents to our view a succession of errors, standing out in bold prominence; each one having, as it rose to its ascendency, supplanted some favorite error which preceded it. Truth, however, let it be remembered, has been all the time more and more developed, by a constant accession to the facts and established principles of our science. And these facts and principles remain as permanent acquisitions, the property of the profession through all time; while its array of baseless but splendid theories and doctrines has passed away, like a succession of dazzling but useless phantasmagoria.

* * *

It is observation, minute, accurate, comprehensive, unbiased by theory, which, proving all things and holding fast that which is good, can rid the medical profession, and through them the community, of the errors and delusions that have prevailed in such diversified forms from the infancy of medicine to the present time. And this is a deliverance which I believe is not only possible, but, if the profession as a body prove faithful to the high trusts reposed in it, is near at hand. I do not believe that the errors of the past must be perpetuated. I do not believe that we need to go on forever confounding the effects of remedies with those of other agencies. I do not believe that it is necessary that the searcher after truth in our science should labor under the incumbrance of theory, or that he should divide his energies between profitless and ingenious theorizing, and the legitimate labor of science, observation. I do not believe, that, in order to develop truth, the mind must at the outset be dazzled by extremes and exclusive views of it — that a leap must be made beyond it over into the region of error, rendering it necessary to retrace some steps to see the truth exactly as it is. I do not believe, that, in order to make observation distinct and clear, it must be shut up wholly, or in part, to any one mode or means. These and other sources of error may be abandoned; and the wide domains of medical science may, even in our day, be secured under the rule of a pure, exact, rational and comprehensive OBSERVATION.

... From the 1850 Fiske Fund Prize Dissertation of the Rhode Island Medical Society, by WORTHINGTON HOOKER, M.D., of Norwich, Connecticut. Baker & Scribner, New York, 1850.

KENNEY CLINIC DAY

Wednesday, October 25, 1961

Pawtucket Memorial Hospital

MEDICAL CRISIS OF THE SIXTIES*

E. VINCENT ASKEY, M.D.

The Author. *E. Vincent Askey, M.D., of Los Angeles, California, President, the American Medical Association.*

MY SUBJECT TODAY is not a light one. The medical profession — indeed, the entire structure of our free society — is in grave danger both from within the country and from without.

Nuclear war threatens, anarchy reigns in Cuba and the Congo, tyranny is constantly trying to crush liberty. Throughout the world we can see the conditions which created Hitler and Mussolini starting all over again. Social disorder and chaos are ripe fertilizer for the swift growth of dictatorship and despotism.

And from within there are dangerous forces acting to undermine our freedom and our rights to live as unfettered individuals.

The international unrest is reflected in renewed efforts by those Americans who believe in an all-powerful central government, one which regulates and controls the lives of all its citizens from the cradle to the grave.

Perhaps those of us in the medical profession are more sensitively aware of this increased threat to our freedoms because we have been selected as a primary target for governmental control.

Perhaps because ours is a dignified, nonpolitical, individualistic profession, we are susceptible to the attacks of those who would achieve their goals by emotional, irrational appeals to the voters.

Gentlemen, I will not beat around the bush or deliver a philosophical discourse.

Rather I want to call you to arms in a war that has two fronts. We must continue to battle for preservation of our medical freedoms against the inroads of governmental intrusion, while at the same time we must strengthen our assault to provide the finest medical care for all our people.

Kerr-Mills Bill

Our battles today involve our defeating attempts to place medical care for the elderly under social security. Also, we must intensify our efforts to implement the Kerr-Mills law — which provides help for those who really need help, the needy and near-needy aged. We must see that the Kerr-Mills law is given a fair chance to prove its exceptional worth in the health care system.

The Kerr-Mills law is one which we fought successfully for, and one which provides the right answer to the problems of health care for the needy aged.

We won a tremendous victory when the last Congress rejected the social security approach and instead passed the Kerr-Mills legislation. It was immediately signed into law by President Eisenhower, and the states started to work implementing it.

Because this law is the embodiment of our beliefs, we must now labor to make it work. Our efforts are essential to the success of this law, especially since the administration has shown no enthusiasm for supporting and promoting implementation of this system of state-federal matching funds.

Just to give you a brief rundown, our latest figures show that the Kerr-Mills program is enjoying phenomenal success in the individual states. Even at this moment some of my statistics may be out of date, for the states are moving at an unprecedented speed to enact suitable legislation.

Right now:

— Eight states and two territories already have the Kerr-Mills program in effect;

— Eight more states have enacted legislation;

— Fourteen states have introduced legislation, and

— Two states have drafted measures to implement the program.

In my opinion, this is remarkable progress, considering the fact that the law is only six months old.

I should also add that the Kerr-Mills program is under consideration in seven states and the District of Columbia. Several other state legislatures will be convening in the coming months, and it is expected that they too will ratify this splendid law.

I believe that it would be tragic to shoulder the wage earners of this country with an additional tax in the form of increased social security deductions before the Kerr-Mills law has been given a chance to prove that it can do the job. This is a plan that

*An address delivered at the dinner session of the 150th Annual Meeting of the Rhode Island Medical Society, at the Sheraton-Biltmore Hotel, Providence, Rhode Island, May 3, 1961.

enables the individual states to guarantee to every aged American who needs help the health care he requires.

The supporters of the social security approach have been deliberately misleading the public so that people will think social security is some sort of insurance system, whereas in reality it is nothing more than a compulsory tax which provides dubious returns to the taxpayer.

The Administration's King Bill

Advocates of the administration's King bill — which embodies the social security approach — say it is "a health care plan for the aged." It is no such thing.

The bill would only provide hospitalization and nursing home care for some old people — those covered by social security. Remember, those who need help the most are those who are *not* covered by social security. These millions of poor and destitute are denied even the limited services provided by the King bill.

Another misleading statement is that the King bill is "a program of prepayment of insurance for future benefits," or "a life policy of paid-up insurance."

Once again, these claims are false and deluding. The Supreme Court has ruled that social security is not insurance and that payments to it are *taxes* — not premiums or contributions.

Remember, the social security system is merely a redistributive tax plan which forces today's wage earners and their employers to foot the bill for payment of benefits to yesterday's workers who today are retired.

Even the social security administration admits that the security of the plan ultimately rests in the taxing power of the federal government and the willingness of the people to pay the taxes.

I don't know how much longer the American people will allow their earnings to be gobbled up by the voracious federal appetite, but once they finally decide they have had enough, the social security system may go out the window, along with the so-called "earned rights" and "insurance" income of all the recipients.

Social security is not insurance; it is a tax. There is no "earned right" to benefits because Congress can scrap the entire system at its whim.

I am not talking as a social security expert. The A.M.A. has never taken an official position on social security, for or against. Our only concern is the threat of Congress adding medical and health benefits to the present system.

Those pushing the King bill are exploiting not only the wage earners of this country but the wage earner's children as well. To operate the King bill under social security would create a permanent debt on which tomorrow's workers and their employers would have to pay interest for the rest of their working days.

I also question the claim made by social security enthusiasts that the King bill guarantees "free choice of physician, hospital and nursing home." As you know, it has been said that "providers of service would be paid on the basis of *reasonable cost* as may be mutually agreed to by the provider of the service and the Secretary of Health, Education and Welfare."

I would like to know what happens when the H.E.W. secretary fails to reach a satisfactory agreement with a hospital or nursing home to which the individual wants to go — does the patient still have free choice? To imply this is to mislead the public.

Also, contrary to its proponents' claims, the King bill will very definitely include physicians' services, since hospital services usually include those of anesthesiologists, radiologists and pathologists.

Also, virtually every hospital requires physician certification before a patient is admitted, therefore, every doctor with a patient in a hospital will be affected by this legislation.

All this uproar over the King bill is really unnecessary, for the Kerr-Mills law will do the job . . . and do it better than any social security proposal.

The Kerr-Mills law has the attractive advantage of being voluntary — not compulsory. It is administered by the states — not the federal government. Each state legislature can determine the needs of its citizens — rather than having the federal government establish one rigid, inflexible standard for all.

Since the King bill is unnecessary and unlikely to be covered by proposed tax increases, it can only be classified as another government spending program which is bound to result in more inflation.

If there is one thing our elderly do not need, it is more inflation. Any aged person who retired a few years ago, thinking that his pension was enough for his needs, knows the bitter cruelty of inflation. This situation will only worsen if the federal government insists on spending our tax money for more unnecessary schemes.

Critics and Opponents

As you know, we have come in for considerable criticism for our opposition to the social security approach. Personally, I don't mind this criticism, since it is part of the price we must pay for our medical leadership. However, I know it bothers many physicians, especially that criticism which is politically inspired and based on emotionalism rather than reason.

We must separate our critics and opponents into two groups; the first is composed of those who disagree with us on ideological philosophy; the second includes those who find A.M.A. a convenient whip-

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ping boy and a steppingstone for their political ambitions.

The first group is one whose opinions we must respect, even though we disagree violently. Every man has a right to his opinion and his belief, and we would be the last ones to deny him the right to hold opinions which do not agree with ours.

"I disagree with what you say," Voltaire said, "but I will defend to the death your right to say it."

This, of course, is our attitude toward those who sincerely believe that the social security system is the ideal mechanism for providing medical care for the aged.

But the other group — those who are fighting us merely for political expediency . . . those who are more interested in the votes of the elderly than in helping them . . . those who have concentrated their venom on the A.M.A. with slander, half-truths and distortions — with this group I have no patience.

I don't mind being criticized or opposed, but I do object to being deliberately maligned just because I disagree with someone.

The medical profession has been profoundly shocked by a member of the Kennedy administration who has made a number of false and misleading statements about the nation's physicians. The H.E.W. secretary, Mr. Ribicoff, has made such remarks publicly on several occasions.

Mr. Ribicoff has accused our association of trying to "frighten" the American people by calling the King bill socialized medicine. He also says we employ "sanctions" against any doctors who do not toe the line and agree with us completely.

This second charge is, of course, ridiculous and does not deserve an answer. All I can say is that in my many years as a physician and active member of A.M.A., I have never seen or heard of any "sanctions" such as Mr. Ribicoff refers to.

On the other matter, the A.M.A. is not trying to frighten anyone. We are simply discharging our responsibilities to the American people by pointing out our fears concerning the King bill.

If Mr. Ribicoff wants to attach political interpretation to our efforts, that is his own business. However, we think it is high time that a man of Mr. Ribicoff's stature — who occupies a position of enormous public trust — begins to be truthful with Americans and should stop trying to camouflage medical care for the elderly behind political sloganeering.

It is doubly distressing that a member of the President's cabinet would attack America's physicians with false and misleading statements while lobbying for his pet bill.

The first time Mr. Ribicoff attacked us, we thought he was either uninformed or badly misinformed. But his continued attacks convince us that he is deliberately trying to impugn and discredit the motive and integrity of America's physicians.

Therefore, our association called Mr. Ribicoff to a public debate to set the facts before the public.

I might add to my remarks about Mr. Ribicoff's reference to sanctions, that a year ago, at least two physician-members of the A.M.A. testified in favor of the Forand bill before the House Ways and Means Committee.

No sanctions have been imposed on them.

Nor will any ever be.

The Congressional Record shows that the physicians were asked if they expected any punitive action by the A.M.A. for expressing their views, and they replied that *they did not.*

Gentlemen, whether we like it or not, each physician must be prepared and willing to get into the fight to preserve our medical freedoms. We must intensify our efforts on behalf of the aged as well as all Americans.

Because of our intense fight, we must expect renewed criticism. As I have mentioned, this is just part of the price we must pay for our leadership. But I certainly think this price is worth the enormous benefits to the health care of our people.

THE CHANGING SCENE IN MEDICAL EDUCATION AND PRACTICE

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ing the changes that are inevitable and making the best adjustment that we can, with the idea that the good of the *public* comes first, that of the *doctors* second.

These are my ideas and my predictions, guesses that may be as good as those of any of us but no better. In concluding I cannot refrain from repeating the famous final remark of Doctor Fuller Albright in his John Phillips Memorial Lecture on Osteoporosis —"Ladies and Gentlemen," said he, "I have told you more about osteoporosis" (and in my case more about the past, present and future of American medicine) "than I know."

DID YOU KNOW?

- **That health insurance benefit payments by insurance companies during 1960 amounted to more than $3.1 billion, eight per cent more than the $2.9 billion paid out in 1959.**
- **That these health benefits averaged out to $8.6 million a day, an increase of more than $600,000 a day over the 1959 average.**
- **That 1960 benefits were higher for all five types of health insurance — hospital expense, surgical expense, regular medical expense, major medical expense, and loss of income.**

TRENDS IN FEDERAL AID TO MEDICAL EDUCATION*

HONORABLE JOHN E. FOGARTY, M.C.

The Author. *Honorable John E. Fogarty, Member of Congress from the Second Rhode Island Congressional District.*

ONE OF MY MAJOR INTERESTS and the focus of much of my activity during the twenty years I have represented Rhode Island in the Congress of the United States has been the health of our state and our nation. Over the years, as chairman or as a member of the subcommittee which has responsibility for, among other things, the annual appropriations of the Public Health Service, I have helped in bringing about a tremendous increase in federal funds available for the support of public health measures, medical and biological research, hospital construction, construction and equipment of research facilities, and the training of research scientists through the provision of research fellowships and traineeships, among other widespread activities and programs.

Although much has been accomplished, much remains to be done to advance our attack upon the diseases and disorders which still afflict our people. Over the past twenty years, and especially during the past ten, largely through the National Institutes of Health, we have built up a great and effective medical research attack upon the chronic diseases which has been remarkably successful.

In that same period we have also helped construct many modern hospitals and research facilities. However, there is one area in which there are inadequacies today and threatened inadequacies of alarmingly increased proportions in the future.

There is serious concern on the part of medical educators concerning recent trends. They report that both the quality and quantity of applicants for admission to medical schools in the United States have been falling off. You and others like you throughout the country can help to remedy this situation. Never before in the history of man have there been greater challenges or more opportunities for achievement than now exist in the fields of medical practice and medical research. As one of you, I personally challenge you to carry on, each of you, through all of the hurdles which yet remain before you, to attain individual levels of professional competency which will enable you to participate actively, to contribute significantly, to achieve with distinction in a field of human endeavor unmatched in the opportunities it offers for worthwhile and rewarding accomplishment.

What are the needs today, and tomorrow, in the field of medical practice? The fact is that we do not have enough physicians today, and the chances are that we may not have enough tomorrow. Looking forward to future needs, a special group of consultants on medical education, the Bane Committee, after a thorough study, reported late in 1959 to the surgeon general of the U.S. Public Health Service that we will need a 50 per cent increase in the number of graduating physicians if we are to maintain the present ratio of physicians to population.

This group of eminent medical advisers, including Father Robert J. Slavin, president of Providence College, stated in its report that the number of physicians graduated annually by schools of medicine and osteopathy must be increased from the present 7,400 a year to some 11,000 by 1975 — an increase of 3,600 graduates each year.

The Bane Committee also reported that this 50 per cent increase in the output of physicians will require expansion of present medical schools and the establishment of *new* ones. It also pointed out:

1. That since it takes about eleven years to plan a new school, construct it, staff it, and carry it forward to its first graduating class, steps would have to be taken immediately if the threatened shortage is to be averted.

2. That, as one partial answer to this problem, federal support should be given to the construction of medical school facilities.

3. That by medical school facilities which should be aided it meant the expansion and improvement of existing medical schools, construction of new facilities for teaching basic medical sciences, construction of new four-year medical schools, and the construction of necessary teaching hospitals.

4. That the provision of the needed support was without question a national responsibility.

I have long espoused in the Congress measures to meet these needs, and some progress has been

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*Read before the Rhode Island Chapter, Alpha Epsilon Delta, of Providence College, at its annual dinner held in Providence, Rhode Island, April 16, 1961.

made. However, with our new administration now dynamically in the picture, I hope I can promise you some real action. However, before I go into this I want to pick up one other item pointed out by the Bane Committee: that nine states have no medical schools. Now, you and I know that Rhode Island has no medical school. I regret the fact that all of you young people will have to leave Rhode Island to pursue your medical educations. I am sure you believe that Rhode Island ought to have a medical school. I know that I do. More than two years ago I published an observation in the CONGRESSIONAL RECORD to the effect that the time had come for our state to have one, and expressed my wish to see such a school established.

I should now like to re-emphasize my faith in Rhode Island as a progressive state and to say that I know we *can* have a medical school here. I do not know how, when, or where. There are many problems, only one of which is financing. Along those lines I promise that I shall continue to exert every effort to reinforce the positive steps taken here in our community.

Like all science, medicine is based upon a constantly increasing fund of basic knowledge about human disease and how biological organisms function normally, and under varying kinds of stress. Therefore a vigorous, vital national program of medical and biological research is a prerequisite to the maintenance of high standards of medical practice. This has been accomplished by means of research project grants to nonfederal medical research institutions throughout the country, through programs which provide funds for the construction of laboratory research facilities, and with research training grants, all administered by the National Institute of Health.

However, this program, by its very success, may have helped create, and certainly has brought to light, problems and needs in the field of medical education and related areas of higher education. These problems have been under intensive study for some time by my committee in the House and its counterpart in the Senate, headed by my distinguished colleague, Senator Lister Hill of Alabama. Our committees, along with a large number of scientists, educators, and administrators, have come to the conclusion that the federal government must do more than simply continue to support more research projects, build more research facilities, and train more research people. We must think not only in terms of the end product we seek — better health for the people of this country — but also in terms of the institutions and the people who compose these institutions that carry on the bulk of the nation's medical research and teaching. Otherwise, the strength of those institutions we support might decline rather than improve.

There are three new programs under way or proposed which are designed to strengthen educational and research institutions and aid the individuals involved, including students.

Institutional Research Grants

The first of these is the recent authorization by Congress of a program of Institutional Research Grants to be administered by the National Institutes of Health. Under this program funds would be provided to public and nonprofit educational or research institutions to assist in the development and maintenance of sound, well-balanced programs of general research and research training in medical, dental, public health, and related areas.

This authorization was made in an effort to help solve the problems generated by the phenomenal growth of research activity in medicine and biology in recent years — problems related to internal administrative responsibilities for a rapidly proliferating number of individual research projects supported by NIH in these institutions.

A large part of that growth has been due to federal grants. Therefore our Committee felt that if clear evidence could be presented concerning real difficulties in our research institutions, corrective action in the federal granting programs would be justified.

I am frank to admit that so far as I am concerned, rather convincing evidence was recently presented by witnesses before our Committee. When that evidence, together with the details of how NIH proposes to administer the program are presented to the Congress, I hope it will win approval.

The Institutional Research Grants would provide funds to universities and medical schools, along with authority to use these funds, as needed, to finance various aspects of their research and training programs in accordance with their over-all objectives. Coupled with assurances of long-term support, these funds would enable the educational institutions to develop their research and training programs in a consistent and planned manner, to provide stable career support for their established investigators and aid to their younger scientists. This program would augment, not replace the system of individual grants to scientists for the support of specific projects.

Clinical Research Facilities

The second new program provides grants for Clinical Research Facilities to non-federal research institutions. Design of the program is in accord with Congressional emphasis on the needs for additional biomedical research resources to facilitate the more complex types of clinical investigations in a broad spectrum of diseases of health-related sciences.

Behind the original Congressional action in establishing this program were the considerations that (1) clinical research has been insufficient because of a lack of adequate means to provide the careful observation and control needed for research in the complexities of human biology; and (2) that valuable research in animals or in chemical laboratories often has not been carried over into studies in human patients because of a lack of proper research facilities and conditions. One of the principal reasons for these deficiencies has been the high costs associated with clinical research.

Under this program grant funds pay for the renovation and equipment of the centers, the costs of the care of research patients (including specialized nursing, diet kitchens, and other services), supporting laboratories, and certain staff salaries. A clinical research facility, as envisioned for this program is defined as a resource within a medical institution aimed at enhancing the quality of clinical investigations. It is a specific physical unit or research ward of about ten to twelve beds in a hospital, but apart from the general care wards, with a stable, well-trained nursing and dietetic staff to provide precise control and observation, and with directly supporting specialized laboratory facilities.

This program is under way and good progress has been made during the past several months. First-year grants, averaging about a half-million dollars each, have been made to nineteen institutions in every region of the country.

In the northeastern part of the country, in our region, these awards have been made:

1. Yale University School of Medicine, $291,105
   New Haven, Connecticut
2. University of Maryland
   School of Medicine 601,868
   Baltimore, Maryland
3. Harvard Medical School 662,033
   Peter Bent Brigham Hospital
   Boston, Massachusetts
4. Seton Hall College of Medicine
   and Dentistry 395,083
   Jersey City, New Jersey
5. Cornell University Medical College ... 650,607
   New York, New York
6. New York University 439,997
   Bellevue Medical Center
   New York, New York
7. The University of Rochester
   School of Medicine and Dentistry 244,696
   Rochester, New York
8. University of Pennsylvania
   School of Medicine 420,421
   Philadelphia, Pennsylvania

Aid to Medical Education

At this point I can almost hear what some of you folks are thinking — something like this, perhaps, "It's all very fine, of course, these programs for the expansion of the research programs in medical schools and other institutions — but, what about individuals like me? I've got immediate problems. I want to go to medical school. The schools themselves may need help, but so do I, and the costs of medical education are high."

Well, I do not mean to suggest that the programs and projects I have mentioned will meet the total need. We in the Congress are equally concerned with the medical manpower problem and we hope to help. We believe the federal government can and should remove a part of the economic barrier which keeps many talented young people from pursuing careers in medicine.

The blunt truth is that over the past several years our medical schools have been losing ground in the competition for superior college students. At the same time our studies have shown that this country has a relative shortage of medical care manpower which will become acute in the near future if steps are not taken.

There are many reasons why this situation has developed, but among them are (1) a tremendous increase in population; (2) the diversion of many medically trained individuals into the greatly augmented programs of research; (3) increasing demands for medical care arising from rising standard of living, expansion of hospital and medical insurance, and the increasing health-consciousness of our people.

Additionally there are other factors, such as the great length and cost of medical training and the development of many other satisfying and intellectually stimulating scientific career opportunities with high prestige and adequate financial rewards.

The financial problems of medical students are severe. We know that over half of all medical school graduates in the 1959 class were in debt to some degree. Medical school tuition costs have continued to rise, and the average cost of four years in medical school was found to be approximately $11,600 for those graduating in 1959. Scholarship support has been meager, and many promising college graduates who would have liked to study medicine have been discouraged.

To correct these imbalances and to provide the federal funds that the medical and related health professional schools need if current and future manpower needs are to be met is the objective of several legislative proposals now being studied in the Congress. I would like to describe very briefly my own bills which I believe would go a long way toward helping meet our national needs in this area.

continued on next page

On January 25 of this year I introduced a bill which would provide for a ten-year program of grants for education in the fields of medicine and dentistry to be administered by the U.S. Public Health Service. Under this program each accredited degree granting medical and dental school would receive a block grant of $100,000 each year, together with $500 for each student, plus additional for each student enrolled in excess of average past enrollment.

For schools providing only one, two or three years of professional training in medicine or dentistry, block grants of $25,000, $50,000, and $75,000 respectively would be awarded.

These funds could be used by the schools to meet the costs of establishing, maintaining, and enlarging their teaching staffs and of maintaining, acquiring and operating the necessary equipment.

Here I should like to emphasize that these funds are to meet the costs of new or expanded instruction programs. Special training projects outside the regular curriculum which are financed with other public funds or private grants are excluded. The same exclusion applies to the costs of research and to the operations of any hospitals.

My bill applies a few conditions for institutional eligibility for federal grants that I believe you will agree are entirely reasonable and desirable:

(1) The school must be either a public or a nonprofit private institution located within the United States.

(2) The school must provide reasonable opportunity for the admission of out-of-state students.

(3) During the period it is receiving federal payments, the school must make every reasonable effort to maintain its income for operating expenses from sources other than the federal government at a level equal to that which existed before receiving the federal funds. In the case of a new school, similar efforts should be made to obtain such nonfederal operating income at the highest possible level.

(4) The school will submit from time to time such reports as the surgeon general may reasonably require to assure that these purposes are being carried out.

To advise the surgeon general on the policies and regulations under which the program would operate, there would be established a National Council on Education for Health. In addition to the surgeon general who would be *ex-officio* chairman and the commissioner of education who would be an *ex-officio* member, the Council would consist of ten leaders in the fields of health sciences, education, or public affairs. Four of the ten would be persons actively engaged in the field of professional health education.

On the day after this first bill was offered, I introduced a second piece of legislation designed to provide scholarships to medical and dental students through the states. Under this plan, each state wishing to participate would establish a Commission on medical and dental scholarships or designate an existing agency to serve as the State Commission. The Commission would develop a plan covering certain broad eligibility requirements which are spelled out in my bill, and which stipulates that the annual stipend paid any individual would not exceed $1,250 of federal funds or one-half the amount of the total awarded to the student. My plan also provides that insofar as possible 75 per cent of federal funds awarded the State Commission must be used for medical and 25 per cent for dental scholarships. Another important requirement is that the State Commission review annually the educational progress being made by each scholarship student.

To finance this program the bill calls for an appropriation of $5 million for the first fiscal year beginning July 1, 1961; $10 million for the next fiscal year; and an equal amount for the next eight years.

The surgeon general will be advised on policies, regulations and administration of this program by a National Advisory Committee on Medical and Dental Scholarships. This group will include the surgeon general, who shall also serve as chairman, the commissioner of education, and ten members appointed by the secretary of Health, Education, and Welfare. Three of these shall be recognized authorities in the field of professional education, three shall be teachers or practitioners in medicine or dentistry, and four shall represent the general public.

Since my bills were introduced, others having the same general objectives have been proposed, following up on the request made by President Kennedy in his health message of February 9 that over the next decade the capacity of medical schools be increased by 50 per cent and of dental schools by 100 per cent.

I am particularly impressed with one of the provisions of one of these which would help expand the teaching facilities in much the same fashion that the research facilities of the schools and universities have been expanded by federal grants in recent years.

Under that provision a new ten-year construction grant program would increase the facilities for training physicians, dentists, and professional public health workers by providing federal funds to match non-federal money for new schools or for major expansion of existing schools. Priorities would be based on the amount of training expansion

the construction would make possible and on distributing training opportunities geographically.

Construction grants could be made for any facility needed in teaching medical, dental, or public health students, including teaching hospitals. Where new schools are being built or existing schools are being expanded, the federal share of construction costs could go as high as 66⅔ per cent. Other grants would not cover more than 50 per cent of construction costs.

The proposed bill would also extend, I am glad to say, the present legislative authority for research facilities grants for three years and strengthen it by increasing the present authorization from $30 million to $50 million annually. The existing backlog of over $60 million in preliminary and final grant applications, gives widespread evidence of overcrowding of available facilities in research institutions throughout the country, and the proposed rapid expansion of training programs all underscore the need to extend and increase the present authority for financing the building and improving of research facilities.

The law would modify the present act, permitting the federal government to meet the total cost of a facility to be used for research and other related purposes, including research training. For other multipurpose facilities, the federal portion of construction costs would be limited to the research part or proportionate use of the facility.

I believe the needs are so clearly apparent that this Congress will take affirmative action of some kind. Whatever that action may be, I will do all in my power to make certain that it does not lead to federal control.

I am committed, as I believe you are, to the principle that teaching at every level and in every field of science must remain free of central domination. It must retain flexibility to meet rapidly changing scientific patterns and the particular needs of diverse geographical areas. Finally, it must truly reflect the wishes of the scientific and academic community. All of these requisites are served best when governmental financial responsibility is shared by nongovernmental funds and interests and guided by nongovernmental advice. My proposals stress this factor, and I believe, reflect the wishes of all who know the importance of maintaining the integrity of teaching, of medicine, and of science.

Fifteen years of experience with the NIH research grants, research training, and research construction grants programs have demonstrated that federal assistance has not brought federal control. Instead they have been programs of, by and for free inquiry. They have nourished freedom rather than restricted it. They have helped stimulate a volume, scope and quality of medical research in this country that has no parallel in history.

By following the same principles I believe we can accomplish the same objectives in federal aid to medical, dental, and related education.

LISTING REQUIREMENTS FOR INPATIENT CARE INSTITUTIONS OTHER THAN HOSPITALS AMERICAN HOSPITAL ASSOCIATION

Approved by Board of Trustees November 21, 1958

1. The institution shall have beds for the care of patients who require continuing planned medical and nursing care and supervision, and who stay on the average in excess of 24 hours per admission.

2. The facility shall be licensed by the state, and shall comply with local governmental regulations.

3. There shall be a duly licensed physician or physicians who shall advise on medical administrative problems, review the institution's plan for patient care, and handle emergencies if the patient's personal physician is unavailable.

4. Each patient shall be under the care of a duly licensed physician, and shall be seen by a physician as the need indicates.

5. There shall be a medical record maintained for each patient, which shall include at least a) the medical history, b) report of physical examination, c) diagnosis, d) physician's orders, e) progress note (medical and nursing), f) medications and treatments given.

6. There shall be arrangements to provide diagnostic services, such as clinical laboratory and X-ray procedures, which shall be regularly and conveniently available.

7. The nursing service shall be under the supervision of a registered nurse, or a licensed practical nurse, with a registered nurse regularly serving in a consultative capacity; and there shall be such other nursing personnel as is necessary to provide patient care twenty-four hours a day.

8. Food served to patients shall meet nutritional and dietary requirements of the patients.

The American Hospital Association may, at the sole discretion of its Board of Trustees, grant, deny or withdraw listing of an institution.

To the Editor:

The Medic-Alert Foundation International wishes to express its appreciation for the article on Medic-Alert which appeared in the March issue of the RHODE ISLAND MEDICAL JOURNAL. This will be of invaluable help in spreading the knowledge of the significance and availability of the Medic-Alert emblems and services.

Again, thank you for your interest and co-operation.

Sincerely yours,
MARION C. COLLINS, M.D., President

Editorials

A MEDICAL SCHOOL AT LAST?

THESE COLUMNS, perhaps self-consciously, can claim a long historical perspective in the matter of medical education in Rhode Island. In Volume I, Number 1 of the Transactions of the Rhode Island Medical Society issued in 1859 it was stated in an account of the closing of the Medical School in Brown University by President Wayland in 1827: "It was, however, found that the proximity of medical schools in Boston, New Haven, and Pittsfield, which were provided with ample accommodations, would always prevent the growth and success of one in Rhode Island."

Forty years later, in 1899, William Osler stated before the Rhode Island Medical Society: "The existing conditions in Providence are singularly favorable for a small first-class school. Here are college laboratories of physica, chemistry, and biology, and modern hospitals with three hundred beds (*sic*). What is lacking? Neither zeal, persistence nor ability on the part of the physicians, but a generous donation to the University of a million dollars (*sic*) with which to equip and endow laboratories of anatomy, physiology, pathology, and hygiene. These alone are lacking; the money should be the least difficult thing to get in this plutocratic town. The day has come for small medical schools in university towns with good clinical facilities."

Word has now come that the impasse may at last have ended. The first unlikely prediction held true for 102 years. The second, reasonable as it sounded, has only now, after 62 years, come to pass. On June 3 of this year the Corporation of Brown University approved a report expected to "lead to the establishment of a program of medical education at the University in the academic year 1962-63." The press release announced authorization "to proceed with the planning and development of an academic program and to obtain funds for the implementation of a six-year program to prepare students for careers either as physicians or as medical scientists." It continued: "The graduate of the proposed course in medical sciences will have the equivalent of two years of medical school work. At that point . . . he may choose to transfer to an existing medical school, with advanced standing as a third-year student. . . . Or as an alternative he may choose to go into teaching or research in the medical sciences, by pursuing two additional years of study leading to a degree of Doctor of Philosophy in a chosen field."

While we welcome the announcement of this long-overdue academic undertaking, we cannot help but have reservations about some features of the project. Most two-year medical schools historically have resulted from a compromise forced by the lack of clinical facilities. Certainly the excellent hospitals in the Metropolitan Providence area are adequate for medical school purposes. We suspect, therefore, that the reservations in regard to a four-year school have a financial and academic basis rather than the usual lack of such facilities. This inference accords with the statement that: "No decision was made by the Corporation at this time as to the addition of the 'two clinical years' of medical education culminating in the award of an M.D. degree at Brown." It is also consistent with the announced "anticipation" of the "not unrealistic" sum of $15 million in capital and endowment funds, compared to the usually stated figure of $50 to $100 million necessary for the establishment of a full-fledged four-year medical school.

If it were not for the distinguished panel of experts and consultants, including three medical school deans who have participated in the formulation of these plans, we should have been inclined to consider them in some respects rather naïve. But with the weight of authority brought to bear we can only ask questions which appear to be unanswered in the preliminary announcement.

We assume on the basis of statements in the announcement that it is planned to select the students for this program in their freshman year. There are several reasons why this may prove highly undesirable. In the first place, few students of seventeen, eighteen, or nineteen are mature enough to embark upon a program of medical education, and fewer still are sufficiently orientated or motivated to know at all, or with any degree of certainty, what type of career they may wish to pursue. It also seems unlikely that suitable students

can be selected that early in their academic development on the basis of tests or performance. Without at least a year or two of college experience to find themselves, many do not know whether they will even care to choose a scientific or a medical career.

Furthermore if pursuit of excellence is a desirable aim in medical education, and we believe it is, no devices should be used which will divert students from seeking the broadest possible liberal education before plunging into the narrowing confines of medical discipline. With glowing promises of an "integrated curriculum," the proposed program attempts "to offer the pre-medical student a rationally planned course of study from the beginning of his freshman year through what would normally be his second year of graduate study in the medical Sciences." Harvard Medical School has striven hard to make "premed" virtually a term of derogation. While insisting on broad academic excellence and an almost irreducible minimum of prerequisite scientific courses (in fact often favoring candidates who have taken only the minimum), it has actually succeeded in attracting an increasing percentage of "A" students, and at the same time students of increasingly broadened interests, to its entering classes, while the trend of academic attainment of medical school candidates has been downward in the country at large.

In regard to the six-year A.B.–M.D. program at Boston University, which incidentally is itself rather ambiguous, it has realistically been pointed out that "some of the students may prove to be unsuited for a career in medicine." Provision is made for replacements for those who drop out. This type of attrition, certainly more characteristic of undergraduates than of students in the better medical schools, is another problem that must be faced. How will the losses from attrition in the twenty-five initially selected candidates be managed? If replacements are selected, the concept of "integration" immediately becomes modified or clouded.

Certainly many students with high academic potential who may plan to enter medical school from Brown will either shun the program completely, or leave it if they have ambitions to enter another medical school. These superior students will be lost to the program, whereas some of them might be picked up under conventional competitive admissions at the end of college. In addition, if it is planned to confine the two graduate years to those students coming up in the six-year program, many excellent candidates who may choose to enter the Brown preclinical years from other colleges will be lost. If it is planned, however, to fill vacancies from outside sources a compromise amounting to the conventional setup of a two-year medical school will inevitably result. We feel accordingly that the proposed plan is rather better calculated to attract students to the biological science departments, than to recruit superior scholars for clinical medicine and medical research. This result is perhaps not unexpected considering the orientation of the faculty panel on "academic feasibility" which has been responsible for drawing up this plan.

We have other reservations. It is rather unlikely, in the long run, we think, that Brown's "outstanding faculty . . . , equipment and physical facilities now available or soon to be acquired," or its Institute of Health Sciences, excellent as these undoubtedly are, can really qualify as the basis for a medical school or medical faculty. The outstanding successful medical schools in the country practically all have facilities and faculties largely additional to and somewhat independent of other college or university complements. Undergraduate or graduate biological science departments are not of the substance or bent required to constitute a first-rate medical school. Experience will eventually bear this out.

Certainly adequate teaching of human anatomy and pathology is of quite a different order than is generally found in academic institutions. Furthermore, hospital affiliations are necessary even in the "preclinical" years for proper orientation in the teaching of these disciplines as well as for the related physical diagnosis now usually taught during the preclinical years. It is certainly highly desirable that the faculty of pathology be actively engaged in hospital practice.

One final thought we think is worthy of mention. Consultations with the leading hospitals regarding necessary affiliations cannot begin too soon. With one of our large hospitals now seeking full-time chiefs of medicine and surgery, it would be a most propitious time for mutual consultations; the task of finding qualified men for these positions will be greatly facilitated, if the prospective candidates can be assured a university teaching position. Close affiliation and integration of the medical school and hospitals should be undertaken during the earliest planning.

CLEAR YOUR MEETINGS TO AVOID CONFLICT

EVERY YEAR the number and variety of medical meetings in Rhode Island has been increasing. This is particularly true in the metropolitan area of Providence with its numerous hospitals and professional groups.

Although conflicts are inevitable as the complexity of the academic programs increases, it is desirable to avoid such conflicts as much as possible.

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When two good programs are planned for the same date and time, it is disheartening to have each suffer because of competition with the other for the available audience. Prospective listeners are also frustrated when they are unable to attend both programs.

Although this type of problem will always be with us to some extent, every effort should be made to minimize it. It should be pointed out that the executive secretary of the Rhode Island Medical Society keeps a registry of meetings. Consultation with this registry will help to eliminate unnecessary conflict.

HYPOCRISY IN THE STATE HOUSE

THE POLITICIANS in the Rhode Island State House are wont to shed crocodile tears concerning the ever increasing costs to the public for coverage by Physicians Service and Blue Cross. It is perfectly obvious, however, to any informed observer that in the majority of instances they are talking out of both sides of their mouths at the same time. Periodically bills have been introduced into the General Assembly to investigate these plans, presumably with the inference that there is some hanky-panky going on. The Director of Business Regulation ordered a massive study of the two plans and then public hearings on the pretext that he has a "responsibility" to the public in these matters. A reading of the "Special Report of the Affairs of the Rhode Island Blue Cross and Physicians Service Plans" prepared for Director Harold C. Arcaro of the Department certainly reveals no significant variations from good practice or efficient administration.

At this writing we are greatly concerned over Governor John A. Notte's performance in regard to recent legislation affecting both plans. The first, relating to Blue Cross, and actually promoted by the governor, requires Blue Cross to pay to certain state and municipally owned hospitals full Blue Cross benefits, whereas previously, on the basis of negotiations, certain partial payments were made. The argument was put forward that, while Blue Cross was paying only nominal benefits in such cases, the insured were paying full premium rates. What was not stated, in line with the policy of half-truths, was that this would cost Blue Cross some $500,000 yearly and result in a *premium rate increase of five per cent.* The legal status of this bill is still in doubt, because of certain legislative errors which have not yet been resolved.

On June 9, almost furtively, the governor signed into law a bill requiring that, if a nonprofit medical service corporation provides services that lawfully may be rendered by a chiropodist or podiatrist, the service contract shall include coverage for such services. The report of this action was hidden in the back pages of the daily newspaper in print so fine as to be almost illegible.

The impact of this legislation on the always delicately balanced finances of Physicians Service will probably be very serious. If every corn and callus is to be interpreted as an "external excrescense" (payable under the contract), the result may indeed be catastrophic. An additional cost will be the payment for X-rays. Of great concern to the medical profession is its inability properly to police sound ethical and professional performance among para-medical groups through its duly constituted committees. An informal estimate of the cost of this new imposition on "The Doctors' Plan" runs to a substantial proportion of one million dollars yearly, out of a yearly premium income (for 1960) of some eight million dollars. The senior citizens, much beloved of the politicians, most of whom pay their own premiums, will find their sore feet expensive indeed.

These performances most certainly represent *Hypocrisy in the State House.*

IMPORTANT LEGAL OPINION

THE ATTORNEY GENERAL of the State of New York, the Hon. Louis J. Lefkowitz, has reversed a decision of a preceding attorney general, making it now legal for registered professional nurses to carry out certain intravenous procedures.

In his opinion, the attorney general said: "Intravenous procedures limited solely to those involving venipuncture by needle and which do not involve incision into or incision to reach a vein reasonably can be considered to be encompassed within the language of the statute giving a registered professional nurse authority to carry out treatments and medications prescribed by a licensed physician."

He added, however, that there appeared to be a need for specialized training for nurses performing the intravenous procedures and urged that the State Education Department recommend inclusion of this procedure in the curriculum of schools of nursing.

In addition, he suggested that hospitals and other nurse-employing agencies in the state establish inservice training programs to qualify nurses to carry out the intravenous procedures.

"Nothing in this opinion should be construed as an attempt on my part to alter or change the legal principles governing the relationship between a

physician and a patient and, in the case of a hospitalized patient, the relationship between the physician, hospital, and patient," the attorney general said.

Since the earlier opinion of 1942, advances and changes in medical practice and in attitudes of both medicine and nursing have made this liberalization desirable.

Experience in World War II and the Korean action explored the technic and proved the acceptability of using trained personnel such as registered nurses for this particular procedure.

Mr. Lefkowitz consulted with the Council of the Medical Society of the State of New York which passed a resolution approving this decision.

The physician who prescribes intravenous therapy to be given by a registered nurse trained in this procedure is fully responsible for this, as indeed he is for any treatment he orders.

. . . Editorial from the NEW YORK STATE JOURNAL OF MEDICINE, Vol. 61, No. 10, May 15, 1961

HIGHWAY SAFETY AND SEAT BELTS

THE PLAN of the automobile industry to provide safety belt attachments in the automobiles of 1962 is an excellent one. It is well known that people who wear safety belts while riding in their automobiles in general survive accidents better than those who do not wear them.

There are, however, two huge problems remaining to be solved. The first is to persuade car owners to buy safety belts (only the attachments will be provided), and the second problem is to get people to use them.

Once the attachments are standard equipment, the automobile industry, the medical profession, and others such as the police, state and local governments, the press, radio, and television should combine to do a real selling job. It will require a major promotional effort, and success will not come quickly.

No one wants to be reminded of disaster while pursuing pleasure. It will not be easy to get the family to fasten seat belts while they are enjoying a pleasant Sunday afternoon drive. It will be the last thing on the minds of young men and their girl friends as they start on an evening of courtship.

With the business of hardware for seat belts out of the way the automobile industry should start building other safety features into the automobiles themselves, such as double-locked doors and steering levers. In the meantime the seat belt attachment is a definite improvement, and it directs attention to the basic fact that safety is everybody's business. Let us all get behind this movement.

MEMBERS ARE INVITED TO SUBMIT ORIGINAL ARTICLES, ABSTRACTS OF PAPERS PUBLISHED IN OTHER MEDICAL PUBLICATIONS, AND LETTERS OF COMMENT FOR POSSIBLE PUBLICATION IN THIS JOURNAL.

RHODE ISLAND HEALTH LEGISLATION, 1961

Report of the Committee on Public Laws of the Rhode Island Medical Society

THE JANUARY, 1961 session of the Rhode Island General Assembly was concluded with a forty-hour continuous meeting ending on June 3, making one of the longest sessions of the legislative body in many years.

All legislation introduced during the session was checked by the Society's executive office, and acts and resolutions of a public health or medical nature were reported to the Committee on Public Laws which, after review, notified various Assembly committees of its opinions. Attached to and made part of this report is a listing of major bills of this category that were enacted, as well as those that were left in committee, some due in part to the action of the Society's report on the dangers inherent in the legislation to the public generally.

Legislation that would weaken the basic science act was protested by the Society, and the bill was not reported out of committee. Similar action resulted in the proposal that chiropractic physicians be compensated for treating public assistance recipients.

Of major interest to physicians was the enactment, after a veto by former Governor Del Sesto for two years, of legislation that would require Physicians Service to compensate chiropodists for services they might render for which an indemnity is payable to doctors of medicine under the service plan's contract with subscribers. The protest of this legislation was handled by the Physicians Service legal counsel and staff, but the bill was acted upon favorably by the Assembly in the final day, and signed five days later by Governor Notte.

The objection of the pathologists of the state to a bill to license clinical laboratories was supported by the Society, and a proposed compromise that a committee of pathologists meet with a committee named by the state director of health after the conclusion of the Assembly session to draft a model act for 1962 introduction was overlooked in the final day and the act passed and signed by the governor. The major question in the minds of many is why an $11,000 appropriation is needed to license and inspect the few clinical laboratories existing outside of the hospitals.

Tenure for the state director of health for a period of five years won Assembly approval. Other legislation enacted included a bill that requires that all public and private schools maintain health programs approved by the director of health and the commissioner of education, requiring that students be tested in their speech as well as their sight and hearing; a bill setting up licensure requirements for social workers, and resolutions approving the use of the Cranston Street Armory for the Rhode Island Medical Society's Sesquicentennial Exposition of Health Progress, memorializing the late Doctor Arthur H. Ruggles, and the late Doctor John E. Donley, and changing the name of the state curative center to the Doctor John E. Donley Rehabilitation Center.

In the field of workmen's compensation, bills upon which the Society's Committee on public laws took no stand were passed which raised the maximum compensation for the totally disabled from $36 to $40, and increased from $300 to $600 the maximum allowable charge in the case of an injured employee hospitalized for not more than two weeks, and from $600 to $1,200 the maximum in the case of an injured employee hospitalized for a longer period, increased the diathermy and massage allowance from $75 to $125, and provided that all hospital fees for treatment and services shall be limited to the prevailing community charges for private patients in semiprivate rooms rather than those in ward accommodations.

In addition to legislation noted above that was left in committee on adjournment, other bills receiving a similar fate included one that would amend the statute relating to the licensure and practice of electrolysis, one that would establish licensure requirements for medical technologists, one introduced by the medical society to allow for physician's lien in accident cases, a bill that would permit the incorporation of professional groups, and many workmen's compensation proposals, including one to provide compensation for occupational deafness, and one that would make it possible for compulsory referral to the state rehabilitation center.

A summary of the major health and medical acts enacted, and those left in committee files, is included.

COMMITTEE ON PUBLIC LAWS
F. B. AGNELLI, M.D., *Chairman*

Rhode Island General Assembly, January Session, 1961, Legislation Enacted

Bloodmobile. S-250. A resolution making an appropriation of $3,000 to be expended by the American Legion, Department of Rhode Island, in the operation of its program concerned with the bloodmobile. Enacted June 12.

Blue Cross. H-1777-A. An amended bill that requires a nonprofit hospital service corporation to pay for services of subscribers in hospitals operated by the state or any municipality of the state on the same basis as all other hospitals. Became law without the governor's signature, Chapter 191.

Civilian Defense. S-113. A resolution memorializing the President and the Congress relative to the establishment of a prompt and affirmative policy encouraging and assisting the citizens of the United States in constructing fallout protection shelters in the event of a nuclear attack. (An income tax deduction for the cost of a shelter, up to $100 per planned shelter occupant, is included.) Enacted April 26.

Clinical Laboratories. H-1519. An amended bill providing for the licensing of clinical laboratories by the State Department of Health, and providing an $11,000 appropriation for the first year. Enacted June 6, Chapter 94.

Evidence. H-1383. A bill permitting contact prints of destroyed records to be admissible in courts as evidence. Enacted June 8, Chapter 148.

Forand-Type Bill. H-1094. A resolution memorializing the Congress of the United States to enact legislation to carry into effect the plan of former Congressman Aime Forand by including medical care to the aged under the social security system. Enacted February 23.

Health Director Tenure. H-1600. Provides for a five-year term for the director of health, full time on the job, with provision that he shall be a physician graduated by an accepted medical college, also skilled in sanitary service and experienced in public health administration, and shall have one year minimum of community graduate instruction in public health administration. Enacted May 29, Chapter 99.

Household Chemicals. S-462. An act providing for the labeling of poisonous chemicals contained under pressure and dispensed in the form of a spray. Enacted June 8. Chapter 132.

Ladd School. S-537-A. An amended bill replacing the advisory commission on Dr. Joseph H. Ladd School with a thirteen-member Governor's Advisory Commission on Mental Retardation. Enacted June 8. Chapter 135.

Physicians Service. S-595. An amendment that would include as purveyors of "medical services" persons licensed as chiropodists or podiatrists. Enacted June 8. Chapter 136.

Polio Vaccine. H-1452. A resolution making an appropriation of fifty thousand dollars for the distribution and use of polio vaccine by the State Department of Health. Enacted March 23.

Memorial to Dr. Arthur H. Ruggles. H-1053. A resolution upon the death of Doctor Arthur H. Ruggles, former director and physician-in-chief of Butler Hospital, and former member of the State Parole Board. Enacted January 13.

School Health. S-467-A. An amended bill providing that all public and private schools maintain school health programs approved by the director of health and commissioner of education, requiring that students be tested in their speech as well as their sight and hearing, and appropriating $15,000 for the testing equipment. Enacted June 8. Chapter 133.

Scituate Hospital Corporation. S-470. An act permitting stated persons to incorporate the Scituate Hospital Association for the purpose of acquiring and holding land, funds, etc., for the purpose of establishing and maintaining a hospital in Scituate. Enacted June 8.

Sesquicentennial of Rhode Island Medical Society. S-368-A. An act permitting the Society to use the Cranston Street Armory for its Health Fair, April 6-17, 1962. Enacted April 27.

Social Workers. H-1152-A. An amended act that provides for the registration of social workers under the board of registration composed of five registered social workers serving staggered terms. The applicant must have a master's degree from a school of social work accredited by the council on social work education or its predecessor. Workers five years in the field within the ten-year period prior to enactment of the law would be qualified under a "grandfather" clause. Enacted June 8. Chapter 146.

State Curative Centre. H-1073. An act changing the name of the Curative Centre of the State of Rhode Island to the Doctor John E. Donley Rehabilitation Center, in honor of the late Doctor Donley, medical director of the centre for fifteen years, and also a past president of the Rhode Island Medical Society and editor of the RHODE ISLAND MEDICAL JOURNAL. Enacted January 31, Chapter 5.

Veterans. S-1160. A resolution opposing efforts to diminish services to veterans at the several United States veterans' administration hospitals throughout the United States, memorializing Congress and other officials in authority, asking that said services shall not be diminished. Enacted February 8.

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H-1075-A. An amended resolution creating a special commission to make a study of departments of veterans' affairs of other states and to determine

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the feasibility of establishing a department of veterans affairs in Rhode Island. Enacted June 6.

Workmen's Compensation

Medical Services. H-1142. An amendment raising maximum charges for medical services to $600 for the nonhospitalized employee, or the employee hospitalized not more than 14 days, and to $1,200 for the employee hospitalized more than 14 days. Charges for diathermy and massage treatments would not exceed $125. Enacted May 24. Chapter 61.

Second Injury Fund. S-620. A bill removing the requirement that the workmen's compensation Second Injury Fund contain at least $250,000 before dependency payments are made from it, and requiring insurers to make payments to the fund when it falls below $350,000, instead of $100,000, and providing for the suspension of payments when the fund exceeds $500,000 instead of $150,000. Enacted June 6. Chapter 82.

Totally Disabled. S-181. A bill raising the maximum workmen's compensation benefits for the totally disabled from $36 to $40 weekly. Enacted June 8. Chapter 123.

Rhode Island General Assembly, January Session, 1961, Health Legislation NOT ENACTED

Basic Science Law. S-161. An act amending the basic science act to eliminate the provision that an applicant "shall also have completed at least one (1) year of preprofessional collegiate education and training in an accredited academic college."

Blue Cross–Physicians Service. H-1090. A resolution creating an eight member legislative commission (5 from the House and 3 from the Senate) to study and make recommendations and propose legislation concerning the operation and rates of Blue Cross and Physicians Service and in the field of health and accident insurance generally in Rhode Island. To enable the commission to engage expert personnel an appropriation of $15,000 is proposed.

NOT PASSED

Charles V. Chapin Hospital Transfer to State. H-1410. An act transferring the C. V. Chapin Hospital from the city of Providence to the state of Rhode Island, and providing for the transfer of the employees from city to state supervision.

Chemical Test Law. H-1370. In substance amends the motor vehicle code to provide that any person who operates a motor vehicle in the state shall be deemed to have given his consent to a chemical test of his breath, blood, urine, or saliva for the purpose of determining the alcoholic content of his blood, provided that such test is administered at the direction of a police officer acting in accordance with the rules and regulations established by the police department of which he is a member and who has reasonable grounds to believe such person to have been driving in an intoxicated condition.

Chiropractic. S-285. The bill would amend the public assistance act to permit chiropractors to treat recipients of state welfare aid through the Division of Public Assistance.

Electrolysis. S-600. A bill amending the act for the licensure of electrologists, providing for apprenticeship under a licensed electrologist for 650 hours within a 9 months period; and setting up qualifications for teaching electrolysis.

Evidence. H-1227. An amendment to Chapter 19 relating to "Evidence" to provide the admissibility in evidence of bills for medical, dental and hospital services in personal injury actions. Under the proposal an itemized bill sworn to by the physician, dentist or hospital agent, would be admissible as evidence of the fair and reasonable charge for such services.

Health Insurance. S-156. An act providing health insurance for state and retired state employees.

Medical Technologists. S-236. An act providing for the licensure and registration of bioanalysis, technologists and bioanalytical laboratories by a board of medical technology consisting of the state director of health, two physicians (one a pathologist) and four technologists who have had ten years of practice, all to be appointed by the governor. Physicians and hospital laboratories would be exempt, except that technologists working for physicians or hospitals would have to be licensed.

Narcotic Act. S-463. An act amending sections of the Uniform Narcotics Act.

Medical Groups, Incorporation of. S-493. An act titled "The Professional Corporation Act of 1961" which would allow individuals duly licensed (i.e., physicians) to form a professional corporation for pecuniary profit under the provisions of The Stock Corporation Act for the sole purpose of rendering the same and specific professional service.

Pharmacy. S-579. Amendments to the pharmacy act that would prevent a registered pharmacist from directly managing, controlling and supervising more than one shop or store, and would also provide that whenever a store is open there shall be continuous supervision by a registered pharmacist.

Public Assistance. S-592. An amendment providing that there shall be a one-year residence for public assistance benefits (there is no residence requirement now) unless there is proof the applicant did not move to Rhode Island expressly to secure P.A.

Physician's Lien. S-136—H-1236. These acts provide that a physician may file a lien on a claim for services rendered to a person injured by rea-

son of an accident not covered by the workmen's compensation act. The lien follows prior liens by the attorney and the hospital.

Public Assistance. S-164. An act amending the public assistance statute to require a one-year residence in Rhode Island before application can be considered for aid.

Workmen's Compensation

Coverage Extended to One or More Employees. S-204. A bill extending workmen's compensation coverage to shops of one or more employees, instead of four or more. H-1069. An amendment to provide that an employer of two or more workers would be subject to the law.

Filing Time for Latent Physical or Mental Impairment. H-1349. An act providing that the time for file claims in cases of latent or undiscovered physical or mental impairment due to an injury shall not begin to run until the claimant knew of the existence of the impairment, or after disablement, whichever is later.

Impartial Examination and Compulsory Use of Curative Center. S-218. An act providing that if injury to the worker involves his back, head, nerves or nervous system, or broken bones, and if compensation has been paid for a period of six months, the Commission would be directed to appoint an impartial medical examiner to examine the employee. The examination would be repeated at six-month intervals as long as the employee continued to be compensated.

The measure would also empower the Commission to *require* any employee to report to the Curative Center for treatment where in its judgment treatment was practicable and likely to speed recovery. Failure to report to the Center would mean a suspension of rights to compensation and possible forfeiture of compensation during the period of suspension.

Injuries "In Course of Employment"; Definition of Personal Injury. S-201. A bill removing the requirement that personal injuries subject to coverage arise "in the course of employment" and be connected and referrable to employment; defining personal injury to include mental or physical damage arising from employment; and extending coverage to include damage or loss of prosthetic appliances.

Occupational Deafness. H-1013. An act providing additional compensation benefits for occupational deafness.

Rate Reports. H-1190. A resolution directing the insurance commissioner to report to the general assembly and explain the reason for the high rates involved in the workmen's compensation insurance program.

Waiver on Pre-existing Physical Disability. S-220. An act permitting the Commission in writing to authorize a waiver of rights to compensation relating to a physical disability existing and known to the employee at the time he obtains work. (Persons with hernia or heart conditions and the like are reportedly unemployable under the present law, and if they could waive disability payments, employers might hire them.)

DISTRICT MEDICAL SOCIETY MEETING

PAWTUCKET MEDICAL ASSOCIATION

The monthly meeting of the Pawtucket Medical Society was held on Thursday, April 20, 1961.

Business affairs of the Pawtucket Medical Society were discussed.

Mr. Thomas Grant of the G. H. Walker Company was the speaker of the evening. The topic was *Investments and the Physician.*

* * *

The monthly meeting of the Pawtucket Medical Society was held at the Lindsey Tavern on Thursday, May 25, 1961, at 8:30 P.M. The following members were present: Doctors Cunningham, Moreno, Fortin, Hogan, Boucher, Schiff, Sonkin, Raheb, H. Hanley, Demopulos, Pinault, Gorfine, Lussier, Billings, A. Jaworski, Hayes, Zolmian, Sod, Yashar, Doll, E. Foster, Metcalf, H. Turner, Mara, Stapans, Barry, Quinn, Hecker, Forgiel, Senseman, Lovering, Lappin, and Liang.

A letter was read from Doctor Charles Farrell requesting a change in membership from regular to associate member. This request was granted.

An application was read from Doctor Edward Spindell requesting associate membership in the Pawtucket Medical Society. This letter was forwarded to the proper committee.

A motion was made and carried that "the members of the House of delegates from the Pawtucket Medical Association introduce a motion at the following meeting of the House of delegates of the Rhode Island Medical Society requesting a detailed breakdown on the financial affairs of the Rhode Island Medical Society."

Doctor Gerald Solomons was the speaker of the evening. His topic was, *The Child Development Study, under the Joint Auspices of Brown University and the U. S. Public Health Service.*

The talk was well received and a general discussion followed.

Respectfully submitted,

ROBERT FORTIN, M.D., *Secretary*

THROUGH . . .  *the Microscope*

North Dakota Physician New A.M.A. President

Doctor Leonard W. Larson, Bismarck, North Dakota, has been installed as the 115th president of the American Medical Association, succeeding Doctor E. Vincent Askey, Los Angeles.

Doctor Larson, 63, one of the nation's leading pathologists, has long been active in A.M.A. affairs. He was a member of the A.M.A. House of Delegates from 1940 to 1950. He served on the A.M.A. Board of Trustees from 1950 to 1960. As chairman of the A.M.A. Correlating Committee on Lay-Sponsored Health Plans, he was instrumental in formulating the "Twenty Principles" covering the relationship between the medical profession and the plans.

Subsequently, he was appointed chairman of the Commission on Medical Care Plans which made a four-year study of such important subjects as free choice of physician and the relationship of the third party mechanism to the practice of medicine.

Doctor Larson was a U. S. delegate to the World Medical Association for four years and a member of the U. S. delegation to the United Nations' World Health Organization in 1952, 1953, and 1959.

For his contributions to the science of cancer control, Doctor Larson received a gold medal in 1953 from the American Cancer Society. He also received a certificate of highest merit from the American Society of Clinical Pathologists.

Born in Clarkfield, Minnesota, of native Norwegian parents, Doctor Larson was graduated *magna cum laude* from the University of Minnesota Medical School in 1922. Following a brief period of general practice in Northwood, Iowa, he returned to the university for postgraduate work in pathology, and joined Quain and Ramstad Clinic in Bismarck in 1924. He has been a clinic partner since 1939.

How Many Hospital Beds Needed?

One of our recent reports on the federal department of Health, Education and Welfare on the status of all Hill-Burton grants for Rhode Island to date shows:

Twenty projects completed and in operation at a total cost of $24,828,934, including a federal contribution of $4,148,814. The projects supply 560 additional beds.

Sixteen projects under construction at a total cost of $14,307,479, including a federal contribution of $3,020,565, and designed to supply 428 additional beds.

Two projects approved but not yet under construction, including above, at a total cost of $885,000 including $107,445 federal contribution and designed to supply 16 additional beds.

For a "crash" program started many years ago to meet an emergency the Hill-Burton plan now appears as a permanent organization, giving further substantial evidence of the procedure that evolves once the federal government gets involved in a spending program.

Surgeon General Appoints Group to Study Nurse Shortage

Secretary Abraham Ribicoff told the surgeon general's Consultant Group on Nursing, meeting in Washington June 12 and 13, that the nurse is the "magic ingredient" in health services.

"If we are expanding in every field of health and medicine, we will be self-defeating if we do not do something about the shortage in nursing," he said.

In support of this point, the secretary's special assistant for Health and Medical Affairs, Boisfeuillet Jones, said that in the past several years the "quite evident shortage became a national problem which has required national attention." He emphasized that President Kennedy hopes the group will outline problems in nursing and the best ways of handling them, and, when necessary, make legislative proposals for their solution.

The group was appointed by Surgeon General Luther L. Terry to further the administration's intention, stated by the President in his February 9 health message, of relieving the nursing shortage and of developing "for nursing, as we have for medicine and dentistry, a formulation of needs and

training requirements" for submission to Congress this year. Doctor Alvin C. Eurich, vice-president of the Fund for Advancement of Education, Ford Foundation, is chairman. Among the twenty-one members appointed to serve with him are nurses, physicians, hospital administrators, educators, and social scientists.

Housewife Holds Key to Family Disaster Survival

A simple recipe for distilling radioactivity out of contaminated water was given by the civil defense chairman of the Woman's Auxiliary to the American Medical Association at its meeting in New York on June 27.

Steps that a housewife can follow to provide safe drinking water for her family were outlined by Mrs. Neil W. Woodward, Oklahoma City, before a meeting of the Auxiliary at the Hotel Roosevelt. The steps to decontaminate water are:

—Thoroughly clean a cookie sheet.
—Place exposed water in kettle over fire and boil.
—Hold cookie sheet at an angle 18 inches above kettle.
—Catch the steam that has been condensed to pure water in an uncontaminated container.

While food, water and shelter are the keys to survival in time of disaster, Mrs. Woodward said that housewives today are either too apathetic or just not taking the time to safeguard their homes against a thermonuclear attack.

Sufficient food and water should be stored to meet family needs for at least two weeks, she said.

"Packaging is more important than the food you select," she said. Containers must be moisture and vermin proof and of a material that will not corrode.

She also cautioned housewives to select foods that need little or no cooking since it may be necessary to heat them over a candle, canned heat or camp stove.

Foods stored in airtight containers may be decontaminated by washing with soap and water, she said. However, the water that is used to clean these foods becomes radioactive and must be disposed of by pouring where it can be covered with earth.

"Bananas and many other foods can be decontaminated by peeling," she said. "But these peelings also are radioactive and must be buried. Burning will not destroy radioactivity."

Mrs. Woodward called on physicians' wives—who make up the 80,000 members of the Auxiliary—to take the lead in getting America's homes prepared for an emergency.

Dartmouth Announces Gift of Medical Students' Dormitory

The Dartmouth Medical School has received from the Strasenburgh family of Rochester, New

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York, financial support in the amount of $325,000 for construction of vitally needed living quarters for medical students, according to a report to the Dartmouth Board of Trustees at its Commencement meeting by Doctor S. Marsh Tenney, dean of the Medical School. With this generous contribution and the recent grant from the Kellogg Foundation for a new auditorium, the Dartmouth Medical School campaign has reached $6,000,000 of its $10,000,000 objective.

Dean Tenney stated that "the new living facility will accommodate approximately eighty medical students and will be located near the new Medical Science building. Its close relationship to the hospital, research and educational facilities of the School will make it an integral part of the developing Dartmouth Medical School campus. By living and studying within the complex unit of a medical center, the spirit as well as the purpose of professional life is continuously apparent to the student. A community motivated by common interest facilitates learning and the acquisition of those ideals so essential for future practitioners of medicine."

Construction of the new medical dormitory is expected to begin late in 1961.

Surprise! Women are Weaker Sex

It may come as a surprise but women really are the weaker sex—at least as far as acute health conditions are concerned.

Although the life expectancy of females is six years more than for males, along the way the average woman can expect to suffer acute health conditions more frequently, resulting in a greater number of days of restricted activity and bed confinement, the Health Insurance Institute said recently. The Institute based its findings on an analysis of data from the U. S. Public Health Service.

In the period of one year, 368 million acute health conditions were reported in the U. S. These conditions, with certain exceptions, are defined as those which last less than three months and which involve either medical attention or restricted activity.

In the surveyed year, women suffered 197 million acute conditions to 171 million for men. This worked out to a rate of 224 conditions for every 100 women, and 205 conditions for every 100 men, said the Institute.

However, the average woman suffered 9.4 days of restricted activity as a result of these conditions compared to 7.5 days for the average man, and also incurred 4.0 days of bed confinement to the male's 3.2 days, declared the Institute.

Women were not ahead of men in all categories of acute health conditions. The survey showed that men more frequently suffered from infectious and parasitic diseases (including viruses), and injuries, while women led in respiratory conditions (including colds), digestive system conditions, and a catch-all category known as "other conditions."

Average Charges in Hospitals Vary by Area, Services, Size

Hospital patients in California, Oregon, Washington, Hawaii and Alaska pay bed-and-board charges averaging 80% more than patients in Texas, Oklahoma, Arkansas and Louisiana.

Average charges in hospitals of the South Atlantic states are 35% lower than those in New England.

The great variability of going rates for hospital services was measured by the American Hospital Association in a survey conducted last year and reported recently.

In over 4,400 hospitals, the A.H.A. found the following average daily charges for private and semi-private (two beds in a room) accommodations, including food services, routine nursing care and minor medical and surgical supplies:

REGION	PRIVATE ROOM	TWO-BED ROOM
New England	$26.20	$21.80
Middle Atlantic	24.10	19.30
East North Central	21.30	17.90
West North Central	18.40	15.50
South Atlantic	17.30	14.10
East South Central	15.70	12.50
West South Central	14.90	12.40
Mountain	19.60	16.40
Pacific	27.40	23.60

Charges for semi-private accommodations with three or four beds in a room generally were 10-15% lower than rates for two beds in a room as of October 1, 1960, the formal survey date.

Returns also showed increasingly higher average charges with increasing size of hospital for the following categories of accommodations: single-bed, from $13 in hospitals of less than 25 beds to $24.30 in hospitals with 500 beds or more; two-bed, from $12.40 to $19.20; and four-bed, from $11.90 to $18.70.

Surgeons Plan Outstanding Clinical Congress in October

Latest applications of surgical research and new surgical techniques will be described at the world's largest meeting of surgeons, the 47th annual Clinical Congress of the American College of Surgeons, in Chicago, October 2-6, 1961.

More than 11,000 surgeons and physicians, from all over the United States, Canada, and many foreign countries are expected to attend this widely instructive five-day meeting. Approximately 1,000 doctors will take part in the program of nine postgraduate courses, 258 new research reports from medical centers throughout the country, 68 medical

motion pictures, 26 cine clinics, 14 operative telecasts from Billings Hospital of the University of Chicago, and 300 scientific and industrial exhibits.

Doctor John T. Reynolds, Chicago, clinical professor of surgery, University of Illinois College of Medicine, is chairman of the committee on local arrangements.

Major addresses will be made by Doctor Robert M. Zollinger, Ohio State University College of Medicine and incoming president of the College, speaking on *Surgical Tithing,* Doctor Francis D. Moore, Harvard Medical School, giving the annual Baxter Lecture on *The Control of Effective Volume and Tonicity; Body Composition,* and Doctor Preston A. Wade, Cornell University Medical School, presenting the annual Trauma Oration, *The Specialist and the Injured Patient.*

This year's historic Martin Memorial Lecture, commemorating the College founder, Doctor Franklin H. Martin, will be given by Admiral Hyman G. Rickover.

More Than Six Million Reported to Have High Blood Pressure

More than six million Americans have high blood pressure, according to a recent issue of *Patterns of Disease,* a Parke, Davis & Company publication for physicians. Of these, the overwhelming majority do not have a heart condition—some 900,000 have both hypertension and a heart condition, while about 5,270,000 are hypertensive without a heart condition.

Among a group of city dwellers, the disease without heart involvement afflicted 66 persons for every 1,000 in the population, compared with 118 per 1,000 among rural dwellers. The disease also strikes about two to four times more often among Negroes than among whites according to *Patterns.*

"A difference of opinion exists as to just what constitutes 'normal' and 'abnormal' blood pressures," according to *Patterns.* "According to one study, the average blood pressure of healthy males, aged 20-24 years, is 123/76. A similar figure, 119/73, is given for males of this age range in another study. According to yet another report, normotension refers to blood pressure below 140/90; hypertension is defined as systolic pressure of 160 mm. Hg and over, or diastolic pressure of 95 mm. Hg and over, or both."

In comparing the mortality rate of persons with high blood pressure with that of persons insured as standard risks, *Patterns* states "the higher the blood pressure, the greater the risk." For every 100 deaths among those insured as standard risks, there are 124 deaths among persons in their thirties with moderately elevated systolic or diastolic pressures, 125 in their forties, and 120 in their fifties. Among those with both systolic and diastolic pressures moderately elevated, there are 184 deaths in the thirties, 170 in their forties, and 147 in their fifties for every 100 deaths among persons insured as standard risks. Sharply higher figures are shown by *Patterns* for those with "markedly elevated" blood pressures.

Check Needs in 'Teen, Senior Years

If your family includes an aged dependent or an aging teen-ager, better check on his or her health insurance coverage, the Health Insurance Institute advises.

At or after age 19, dependents' coverage may terminate under your family plan. Or the dependent may continue to be covered to age 23 or even 25, provided he is still at school or college.

What should you do if you have a youngster leaving the protection of the family health insurance plan?

If he is going to work, he should ask the employer or personnel director about the firm's health benefits program. If the employer is paying part (or all) of the premium costs, the group program should be particularly attractive.

A wide range of individual policies also are available. Rates for young people are comparatively low. By shopping around, you may find a policy that fits your ex-dependent's needs and situation to a "T."

Choice for Older People

For your aged dependent, you also have a varied choice of individual insurance plans to help cover his or her health costs. A representative list of policies now available to the aged from more than 100 insurance companies, including an outline of benefits and premium costs, will be mailed you upon request to: Health Insurance Institute, 488 Madison Ave., New York 22, N. Y.

If it is still pre-retirement for an aging parent or in-law, he or she should find out whether their group health coverage on the job can be converted to an individual policy or continued upon retirement. An increasing number of plans are being written that may be carried into retirement, often

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with the employer contributing part (or all) of the costs.

Health insurance also is available to people 65 and over, regardless of physical condition, through mass enrollment plans. Enrollment dates are announced by the insurance companies in newspaper and other advertisements at periodic intervals.

Enrollment at all times is open in various organizations existing for other purposes, such as associations of retired teachers, which in addition offer group-type health insurance plans.

Hospital Benefits Vary Among States

Hospital daily room-and-board benefits provided through group health insurance policies issued during 1960, and averaged by state, ranged from a high of $18 to a low of $11, the Health Insurance Institute reported recently.

The benefits provided for miscellaneous hospital services, and the maximum surgical benefits, also varied widely, the Institute said in its report which was based on an analysis of data supplied by insurance companies which account for 68 per cent of the total group health insurance premiums in the United States. The hospital data sampling consisted of 851 basic group coverages issued during 1960 protecting more than 67,000 employees and most of their families.

The average daily room-and-board benefit for all the new coverages was $14, but the average was $11 for the states of Kentucky, Mississippi, North Carolina and Oklahoma and was $18 for the states of New Jersey and Vermont, said the Institute. Similarly, there was a range in provisions for miscellaneous hospital expenses such as X-rays, laboratory charges and operating room charges.

The difference in benefits among states reflects the fact that living costs vary greatly by area, resulting in corresponding levels of hospital rates, the Institute pointed out. It added that a 1960 survey by the American Hospital Association disclosed the average charge for a bed in a two-bed semi-private room was $21.80 in New England, and $14.10 in the South Atlantic states.

The Institute also said that, because benefits are available at whatever level the buyer desires, the range of benefits actually purchased reveals the wide difference in what employer or contract negotiating groups feel is needed to provide adequate health insurance protection.

Surgical benefits provided also had a wide range among the states. The Institute said the maximum benefit purchased for a surgical procedure averaged out to a high of $350 in California, and to a low of $190 in Kentucky. The average for all states was $280, said the HII.

Some of the other states with high average maximum benefits for surgery in the new coverages were South Dakota with $335, Oregon and Washington with $330. Ten other states had $300 or more.

1960 was Big Year for Accidents in U. S.

The year 1960 produced a heavy toll of accidents in the United States with more than 46 million persons being injured, the Health Insurance reported recently.

Because of a high rate of accidents in the last two quarters of 1960, there was a total of 46.4 million persons injured, exceeding by 3.4 million the 43 million persons injured in 1959, said the Institute. For every 1,000 population, there were 263 persons injured in 1960, compared to 249 in 1959.

The report was based on information developed by the household interview program of the U. S. National Health Survey on the number of persons experiencing injuries causing one or more days of restricted activity or requiring medical attention.

For the first six months of the year, 1960 was running behind 1959 in the number of persons injured in accidents, and it appeared possible that the year would end with a smaller total than 1959, just as 1959's total of 43 million persons injured was down from the 1958 figure of 47.1 million.

However, in last year's summer months of July, August and September 14.5 million persons were injured in accidents, compared to the corresponding 1959 summer figure of 12.8 million persons injured. And in the last quarter of 1960, some 11.4 million persons were injured compared to 9.5 million in 1959's final quarter, said the Institute.

Motor Vehicles

There was an increase in persons injured last year in each of the Survey's four categories of accidents—motor vehicle, while at work, home, and all other.

There were five million persons injured in accidents involving motor vehicles in 1960, up from 3.9 million in 1959, which was a decrease from the 1958 figure of 4.3 million. Some 8.7 million persons were injured while on the job, the same number as in 1958, but up from the 1959 figure of 8.3 million persons.

Home continued to be the most dangerous spot, said the Institute. A total of 19 million persons were injured in the home in 1960, an increase over the 1959 total of 18.6 million persons, but down from the 1958 total of 20.2 million persons. All other accidents injured 13.8 million persons last year, compared to 12.2 million in 1959, and 13.9 million in 1958.

Check the date . . .
Wednesday, September 27, 1961
HOUSE OF DELEGATES MEETING
at 8:00 P.M.
